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**Embodying 'Active' Ageing:  
Bodies, Emotions and Risk  
in Later Life**

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## Abstract

The promotion of ‘active’ ageing in later life has been a key development in recent health policy. These changes not only challenge the prevalent view of old age as an inevitable process of biological decline but signify the tendency of lay and expert discourses to increasingly use the notion of risk. Older people’s social identities also need to be negotiated in the context of positive (*active/freedom/fluid*) and negative (*passive/dependence/decline*) images of ageing. This thesis explored older people’s social identities; meanings about lifestyles, emotions, and bodies; and the salience and limitations to ‘risk’ and ‘reflexivity’ within everyday life. The research involved the intersection of in-depth qualitative interviews with photo-elicitation with 50 men and women aged between 50 and 96 years. Thematic analysis using Atlas Ti was undertaken. Three interconnected themes emerged:

- 1) Participants experienced their bodies as a taken-for-granted aspect of their everyday lives until moments when an awareness of the body interrupted their daily activities. At these moments the everyday visibility of the body was heightened and participants reflected on their own meanings and identities about ageing.
- 2) Emotions were significant as participants described their everyday lives and social interactions. There was a continual tension between inner (private) subjective feelings and *experiences* of emotions and the outer (public) bodily and spatial *expression* of these emotions.
- 3) Reflexive meanings about risk were multifaceted as participants drew upon diverse discourses when making choices about health-related lifestyles. A sense of embodied vulnerability associated with ageing was evident.

Meanings and perspectives associated with ageing bodies were therefore central to everyday experiences of growing older. Alternative images of ageing were intertwined within the accounts of the participants as they fluctuated between a sense of ageing as a time of possibilities and a heightened awareness of their embodied vulnerabilities.

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## **Declaration**

The research conducted in this thesis is all my own work and has not been submitted for a degree at another university.

In loving memory of my Dad

Peter James Martin

1923 – 1998

## Introduction

*When we look at the image of our own future provided by the old we do not believe it: an absurd inner voice whispers that **that** will never happen to us – when **that** happens it will no longer be ourselves that it happens to ...*

*We must stop cheating: the whole meaning of our life is in question in the future that is waiting for us. If we do not know what we are going to be, we cannot know what we are: let us recognize ourselves in this old man or in that old woman. It must be done if we are to take upon ourselves the entirety of our human state*

(Simone de Beauvoir, 1970, p. 11 – 12)

Simone de Beauvoir (1970) passionately warns us against viewing old age as the ‘other’. She questions the predominant age distinctions between ‘us’ and ‘them’ in which old age is constructed as a separate and distant entity rather than as an extension of our future (and present) selves (Andrews, 1999). For de Beauvoir, old age is a continuation of our biography and part of our identity that must be embraced. Moreover, the costs of ignoring old age are high, for not only do we divorce ourselves from the potentiality of our own futures (when we become ‘old’ ourselves) but we diminish the meaning of our immediate lives in the here and now (Andrews, 1999).

The inclination to marginalize the experiences and meanings associated with later life persists. Old age has, for example, been noted for its muted and uncertain presence in



disciplines, such as, medical sociology (Bury, 2000), feminism (Arber and Ginn, 1991; Calasanti and Slevin, 2001; Twigg, 2004) and the sociology of the body and emotions (Öberg, 1996; Faircloth, 2003; Wainwright and Turner, 2003; Twigg, 2004). Dualist tendencies also predominate within the study of old age. Cartesian dualisms in which the mind / body, the social / biological are constructed as distinct and separate entities (Williams and Bendelow, 1998) are clearly evident. In part this is due to the legacies of biological determinism (Williams and Bendelow, 1998) and the privileged biomedical accounts of ageing. The dominant narrative of ageing as a process of decline and decay have resulted in an emphasis on the bodily being seen as potentially demeaning for older people (Faircloth, 2003; Twigg, 2004). A long history of biological determinism and a misogynistic discourse, that reduces women to their bodily characteristics, has rendered a focus on the bodies of older women especially problematic (Twigg, 2004). Dualisms that separate mind from body, nature from culture, reason from emotion, are not only pervasive but also map onto wider differences, between men and women, the public and private, and the young and old (Williams and Bendelow, 1998). Biological and bodily processes associated with age and ageing whilst appearing 'natural' can therefore only be understood in the cultural and social context in which they exist (Hepworth and Featherstone, 1998; Öberg, 2003).

The distinctions that de Beauvoir (1970) describes between 'us' (the 'young') and 'them' (the 'old') are, of course, not morally neutral and in contemporary Western societies denote bodily differences in which young bodies are seen to have higher symbolic value than old bodies (Faircloth, 2003; Twigg, 2004). As Gullette (1997,



2004) argues “we are aged by culture”. In contemporary western societies age has become an increasingly significant determinant of cultural and social value; paradoxically the more we age, the less social and cultural value we have. For decline and dependence, the key symbols associated with growing older, are a reminder of the possibilities of failure and loss of control in a society constructed on values of progress, control and independence<sup>1</sup>. To alleviate these tendencies Gulleto (2004) argues that ageing needs to be brought into mainstream Sociology and age recognized as a key determinant of social location, alongside other key factors, such as gender, ethnicity and social class. A focus on the cultural aspects of ageing would furthermore open up the possibilities of understanding more about the dynamic processes that lead to the progressive social and cultural exclusion of people as they grow older.

The focus in recent years on the promotion of active ageing brings into sharp relief these alternative discourses of ageing. A significant development in health promotion has been to establish a connection between health, a healthy lifestyle and positive ageing in later life (Hepworth, 1995). Age is no longer seen as a barrier to health promotion activities, and all people, irrespective of their chronological age, are encouraged to adopt healthy lifestyles. This is indicated in a series of policy initiatives that promote healthy living in later life and advocate changes to health related behaviours in relation to known risk factors, such as, diet, exercise and smoking. Underlying the concept of active ageing is, therefore, the idea that people in

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<sup>1</sup> Gulleto situates her debates in contemporary America but her debates clearly resonate with the context in the UK.

later life can make significant changes within their everyday lives to promote their physical and emotional wellbeing. Age and ageing are therefore embodied within recent policy initiatives that promote the idea of an active mind as well as an active body.

These developments signify important changes to both our concepts of 'risk' and 'ageing'. The emphasis on the identification of risk factors related to health reflect the tendency for both lay and expert discourses to increasingly use the notion of risk (see Giddens, 1991, 1998; Davison *et al.*, 1991, 1992; Beck, 1992; Williams and Bendelow, 1998; Lupton, 1999; Tulloch and Lupton, 2003). In an era of reflexive modernity, risks, with the associated uncertainties of an unknown but anticipated future, are seen as important factors in the way people organise their everyday lives. Significantly, for older people, it is within the context of alternative images and discourses of positive (*active* / freedom / fluid) and negative (*passive* / dependence / decline) ageing that lifestyles, self-identities and bodies are to be negotiated. As the prevalent view of ageing as a process of a passive, biological and inevitable decline has been challenged (Victor, 1991; Ginn and Arber, 1995; Gilleard and Higgs, 2000; Bury, 2000), old age is increasingly viewed as a time of possibilities and opportunities (Giddens, 1998; Bury, 2000; Williams, 2003). For Giddens, 'in the more active, reflexive society, ageing has become much more of an open process' (1998, p.119). In this context, the ageing body is no longer a "given" and is less restricted by previous limits and constraints (Shilling, 1993).



The central concern within this thesis is to explore a key tension within the promotion of active ageing: how do you marry the promotion of ageing as a time of possibilities and opportunities with the inevitable onset of decline, deterioration and decay of an ageing body? For two alternative discourses of ageing, that resonate with the uncertain and contradictory solutions that consumerism has in response to the inevitable onset of decline, deterioration and decay (Shilling, 1993; Featherstone, 1995), are evident. A first 'positive' image shows the possibilities and opportunities of later life and the pleasurable pursuits and consequences associated with health and healthy lifestyles. These images portray health, vitality and activity and convey an ageless and timeless social world. However, to ensure that individuals both engage with health promotion discourses, and are vigilant about their body maintenance regimes, a sense of fear associated with ageing, decay and death also needs to be instilled. These more 'negative' images are associated with perceptions of heightened risks to health, bodily vulnerabilities and dependence associated with growing older.

These 'positive' and 'negative' images of ageing are, however, not neutral concepts but 'moral categories' in which 'positive' lifestyles are promoted and 'negative' ways of ageing actively discouraged (Hepworth, 1995, p.177). The proliferation of new 'positive' terms for mid to later life such as "baby boomers", "third agers", and "new middle agers" also gloss moreover many inequalities and experiences of poverty associated with later life (Katz and Marshall, 2003) and excludes experiences of deep old age and / or of care (Twigg, 2004). These concerns and dilemmas are however predominately left with older people themselves as they negotiate their personal and

social identities around ‘positive’ and ‘negative’ images of ageing in the context of these newly emergent identities, bodies and lifestyles.

### **The Research Study**

The research study explored: (1) how older people negotiated their social identities in the context of alternative images of ageing; (2) older people’s own meanings and perspectives about their lifestyles, self-identities and bodies; and (3) the salience and limitations to the concept of ‘risk’ and ‘reflexivity’ in the context of older people’s everyday lives. The research approach was qualitative and involved 50 in-depth interviews with a diverse group of men and women aged between 50 and 96 years old. The research design involved the intersection of the following data collection methods:

(1) In-depth interviews with 50 people aged between 50 and 96 years.

(2) Photo-elicitation, as part of the in-depth interviews: a form of ‘vignette’.

Thematic analysis using Atlas Ti was undertaken. In order to redress the dualist tendencies cited above this research explored a *lived body* approach. The rationale for a lived body approach was that it not only reflected an ethical stance in which I was committed to non-dualist forms of analysis, but focused attention on our embodiment, i.e. the centrality of bodily perceptions and experiences to our being in the world (Merleau-Ponty, 1962; Williams and Bendelow, 1998; Nettleton and Watson, 1998). Leder (1990) further argues that a focus on lived experiences may start to ameliorate some of the negative effects of dualist hierarchies that have led to some social groups being defined as ‘other’.



In this context, I took a phenomenological perspective to explore, understand and report the experiences and views of men and women in mid to later life. In particular, it was important to me to place the participants' own voices at the centre of this thesis in which my analysis and critique arose from the discourses of the participants about their everyday lives. At the same time I have also situated these discourses within the cultural, social, visual and embodied context in which they exist. In this sense, this thesis also has a feminist goal: my vision has been to engage with and value the experiences of men and women that have previously been obscured, discarded, or devalued (cf. Furman, 1997; Ribbens and Edwards, 1998). In particular, my aim has been to bring the perspectives and experiences of older men and women into public view. The accounts documented in this thesis are culturally specific to the socio-historical context in which the research was undertaken.

### **Structure of Thesis**

This thesis reports my research study. Chapter 1 gives a more detailed account of the background to my research. Through an exploration of the meta-theme of *active / passive* images of ageing this chapter discusses the promotion of active ageing in recent years. This includes an exploration of the salience and limitation of the concepts of 'risk' and 'reflexivity'; the significance of the 'mask' of ageing (Featherstone and Hepworth, 1990, 1995a, 1998) as people negotiate social identities in later life; and the centrality of bodies and emotions as we grow older. In particular, this chapter explores the interplay of bodily processes associated with age and ageing with the cultural and social context in which they exist. A lived body approach is proposed as a way to overcome the prevalent dualist tendencies evident in ageing



studies. Chapter 2 focuses on the research process and my own personal journey as a gendered and embodied researcher. There are two sections to this chapter. The first section explores some central methodological considerations that researchers face when studying health, ageing and bodies in everyday life. In the second section, the actual data collection methods and my experiences of being a researcher in the ‘field’ are described.

In chapters 3, 4 and 5, I thematically present the data that emerged from the in-depth interviews and photo-elicitation methods. Chapter 3 explores the lived *experiences* of and the ‘*doing*’ of age, ageing and the body in context of the participant’s everyday lives. This chapter shows how the participants experienced their bodies as a taken for granted aspect of their everyday lives until moments and / or times when an awareness of the body interrupted their daily activities. The ageing body was therefore neither a constant presence nor an absent entity but an (in)visible transient and fluctuating absence / presence within their everyday lives. Chapter 4 highlights the significance of gender, emotions and ageing in the context of everyday life. Emotions were interwoven throughout the participant’s discourses as they described their everyday lives and social interactions. The intensity of these emotions was especially heightened at critical moments within their biographies, such as, bereavement, divorce and retirement. In particular, this chapter shows a continual tension between the inner (private) subjective feelings and *experiences* of emotions and the outer (public) bodily and spatial *expression* of these emotions. Chapter 5 focuses on the meanings, perspectives and concerns that participants expressed about their health, health-related lifestyles and perceptions of ‘risk’. This chapter will show

that the process of risk profiling and reflexivity was complex and multifaceted as participants drew upon a number of different discourses when making choices about health related lifestyles. This chapter concludes by showing that underlying the participant's discourses about health and risk was a sense of embodied vulnerability about ageing in which old bodies were constructed as 'other' to be avoided and distanced from their everyday worlds.

On the basis of the data collected, chapter 6 discusses the implications of the two alternative images evident within the concept of *active* ageing to the lived experiences of people in mid to later life. It will be shown that underlying the discourses of the participants was a moral distinction between presenting a 'positive' image of a performing and *active* embodied self in the public world whilst minimising and / or hiding perceived 'negative' aspects of growing older. In particular, the participants drew upon discourses in which old bodies were constructed as 'other' and thereby to be distanced and avoided. Participants were therefore continually fluctuating between a sense of ageing as a time of possibilities, and an awareness of their embodied vulnerabilities, for these opportunities were solely dependent on the integrity and well-being of their ageing bodies. Meanings and perspectives associated with ageing bodies were therefore central to the experiences of growing older. This thesis therefore highlights the significance of understanding lived experiences of ageing bodies in relation to the social and cultural milieu. The thesis concludes by voicing a concern that the promotion of active ageing may inadvertently lead to the cultural repression of old and declining bodies that may

diminish the quality of life of people living into deep old age and / or with bodily limitations.



# 1

## **Health, Risk and ‘Active’ Ageing: situating the research context**

*It is taken as quite natural that old age is a time of biological decline, which results in the whole population of older people being characterised by ill health and sickness. To be old is to be unhealthy*

(Victor, 1991, p.1)

*Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age*

(World Health Organization (WHO), 2002, p.12)

Within the literature there are two broad but distinct and alternative images of ageing (Bury, 2000; Williams, 2003). The first image and / or discourse portrays ageing as a time of possibilities and opportunities: an ‘optimistic’, fluid and ‘positive’ perspective on later life. In contrast, a second image and / or discourse is evident that emphasises ageing in terms of dependence, decline and disadvantage: a more ‘pessimistic’, passive and ‘negative’ perspective on old age. These alternative discourses are also clearly evident within the concept of active ageing that alternate between ‘positive’ and ‘negative’ images of old age (cf. Shilling, 1993; Featherstone, 1995; Hepworth, 1995). Whilst the ‘positive’ image suggests that many opportunities are possible in later life, highlighting pleasurable things in the present, and enjoyable activities and outcomes associated with body maintenance regimes, such as, diet and

exercise. These images show health, vitality, activity and convey an ageless and timeless social world. However, to ensure that individuals both engage with health promotion discourses and are vigilant about their body maintenance regimes a sense of fear associated with ageing, decay and death also needs to be instilled. These more 'negative' images are associated with perceptions of heightened risks to health, bodily vulnerabilities and dependence associated with growing older.

These alternative images moreover signify a key problematic within the concept of active ageing: how do you marry the promotion of ageing as a time of possibilities and opportunities with the inevitable onset of decline, deterioration and decay of an ageing body? These issues are examined in this chapter through an exploration of the following interconnected and substantive themes: (1) the promotion of active ageing; (2) healthy lifestyles, 'risk' and 'reflexivity'; (3) consumer culture and images of ageing; (4) masking theories and experiences of ageing; and (5) ageing, the lived body and everyday life.

### **The Promotion of Active Ageing**

Within the last twenty years there has been a major change in the focus of policies for older people. Older people are no longer viewed as dependents and recipients of a paternalistic welfare system but have been reframed as consumers and participants of welfare who not only make active choices but shape the welfare agenda (Gilleard and Higgs, 2000). This transformation is reflected in strategic and policy developments that promote key concepts such as consumerism, empowerment and participation. This is resultant from a multiplicity of profound societal (and global) changes in the



late 20<sup>th</sup> and early 21<sup>st</sup> century that include the ageing of Western populations (Katz and Marshall, 2003; Estes, *et al.* 2003; Vincent *et al.*, 2006); changes in demographic patterns (Victor, 2005); transformations to work, retirement and pensions (Davey, 2002; Vincent, 2003; Fairhurst, 2003a; Victor, 2005); the emergence of the new public health (Petersen and Lupton, 1996; Fairhurst, 2005); responses to ageism in which old age is categorised in ‘negative’ terms of decline and ill health (Hepworth, 1988, 1995; Gilleard and Higgs, 2000, 2005a); and the blurring of age and generational categories between middle and old age (Featherstone and Hepworth, 1990, 1995a, 1998; Gilleard and Higgs, 2000; Katz and Marshall, 2003). The consequential changes to definitions of age and ageing across the life-course clearly demonstrate how the category of old age is socially constructed (Katz, 1996; Vincent, 2003).

These changes are vividly illustrated in relation to policies associated with health, health promotion and active ageing. As Hepworth (1995) argues a key development in health promotion has been to establish a connection between health, a healthy lifestyle and positive ageing in later life. Age is no longer seen as a barrier to health promotion activities and all people, irrespective of their chronological age, are encouraged to adopt healthy lifestyles (Bernard, 2000; Chiva and Stears, 2001). Underlying these initiatives is the argument that older people can gain significant benefits by changing their health related behaviours in relation to known risk factors, such as, exercise, smoking and diet. Health promotion discourses have further embraced the language of self-care, ‘empowerment’ and personal responsibility (Bernard, 2000; Katz and Marshall, 2003). Older people are therefore not only asked

to take responsibility for their own individual health but to demonstrate a wider commitment to the collective health of an ageing population (Katz and Marshall, 2003): participation can therefore be seen to also denote relationships of citizenship and duty (Petersen and Lupton, 1996).

These wider discourses focus attention on an ethical dimension underlying the promotion of active ageing; for self-caring, responsible and risk adverse lifestyles are normalised (Hepworth, 1995; Katz and Marshall, 2003) whilst ‘other’ self indulgent and dependent lifestyles are actively discouraged (Hepworth, 1995). This is achieved by:

*normalising styles of ageing prescriptively designated as “positive” (i.e. as the bodily evidence of “rational” and independent individual lifestyles) and discouraging or even punishing styles of ageing defined as deviant (i.e. “irrational”, self-indulgent and above all conducive to social dependency)*

(Hepworth, 1995, p.177)

This can have the effect of promoting a climate in which fear into old age predominates. It is possible that the promotion of positive and active ageing may have the paradoxical effect of increasing the cultural repression (Tulle-Winton, 1999) of the ageing and declining body. Older people may now be compelled to negotiate their social identities in an era when images of dependency, ill health and decline of ageing bodies have become increasingly hidden <sup>2</sup>. In this context ageing becomes

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<sup>2</sup> A process Giddens (1991, 1998) refers to as the ‘sequestration’ of experience in high modernity



socially regulated through demographic and policy categories of risk and dependence (Katz, 1996; Katz and Marshall, 2003).

With the current prominence of active ageing it is hard to imagine that the associations of activity and old age are relatively recent (Katz, 2000). As Katz argues, in the early 20<sup>th</sup> century ageing and retirement were associated with contemplation and rest, not with continual activity. This is illustrated by the reasons given by residents of nursing homes to explain their long life: “all praise early retiring and insist that a generous portion of the twenty-four hours must be spent in bed, even if they do not sleep” (Hall, 1922, cited in Katz, 2000, p. 139). The ideal of activity and problems of adjustment in old age did not emerge until the postwar period. Since this time leisure has become increasingly reinvented as activity; old age rationalised and managed within a discourse of ‘activity’<sup>3</sup>; that has resulted in what constitutes an activity being reinscribed <sup>4</sup>. In consequence, the everyday lives of older people have become increasingly managed through discourses of activity: old bodies are now delineated as ‘busy’ bodies.

Concepts of active and positive ageing have recently been further incorporated into key policy and strategic developments in the UK. During the 1990s there was growing concern about the lack of involvement of older people in health promotion

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<sup>3</sup> During the late twentieth century there was a significant increase in standardized frameworks, such as *Activities of Daily Living*, and activity programmes for older people and older people with dementia. See Katz (2000) for a full account.

<sup>4</sup> Katz (2000) summarises key ambiguities evident within the standardised frameworks and research associated with activity. These include: (1) what constitutes active / passive behaviours, for example, how to define daytime napping and watching television; and (2) the difficulties associated with measuring the totality of activities in later life, even in institutional settings.

policies (Hepworth, 1988, 1995; Ginn *et al.*, 1997; Killoran *et al.*, 1997) with no coherent and population based strategy aimed to promote the health of older people (Munro *et al.* 1997; Nutbeam, 1998). Alongside wider initiatives and reports, a national response to this apparent oversight was evident within the new public health document *Saving Lives: Our Healthier Nation* (Department of Health (DoH), 1999) which made direct reference to the inclusion of all people irrespective of chronological age<sup>5</sup>. These developments signified a direct challenge to the prevalent view of later life as a passive and stable process of inevitable decline. Alongside the whole population the possibilities of ageing as a time of health, activity and vitality were portrayed (Blaikie, 1999) as a move towards disconnecting older people from the categorisation of old age as a time of ill health and frailty (Gilleard and Higgs, 2000).

A wider exploration of these initiatives does however show the varied and uncertain position of older people within new public health documents. There is a tendency for older people to be categorised as distinct and separate from the rest of the population. This is illustrated by the publication of a number of key strategy documents and reports that focus solely on the needs of older people, such as, the *National Service Framework for Older People*, Standard 8, (DoH, 2001); *Active Ageing: A Policy Framework* (World Health Organisation, WHO, 2002); *Better Health in Old Age*, (DoH, 2004a); *Promotion of Physical Activity among Adults* (Cavill *et al.*, 2006); and

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<sup>5</sup> It is well documented that this document was a New Labour response to the increasing evidence of widespread inequalities of social class, gender and ethnicity, evidenced through papers such as: Townsend and Davidson, (1982) *The Black Report*; DoH (1995) *The Acheson Report*; Shaw *et al.*, (1999) *The Widening Gap*.



*A New Ambition for Old Age* (DoH, 2006a). In the most recent new public health document *Choosing Health. Making Healthy Choices Easier* (DoH, 2004b) and the governmental campaign *Small Change, Big Difference* (DoH, 2006b, Flint, 2007) reference to older people is either implicit and / or promoted alongside these wider all embracing strategies<sup>6</sup>. The health promotion needs of older people, whilst no longer disregarded, are constructed as different and specialised.

The terminology used in the advancement of ‘healthy’ ageing is also value laden (Bartlett and Peel, 2005). Quality of life has been conceptualised as ‘successful’ (Rowe and Kahn, 1997), ‘active’ (WHO, 2002), ‘productive’ (Davey, 2002), ‘positive’ (Bowling, 1993, 2005) and ‘healthy’ (Bartlett and Peel, 2005). The preferred term in America is ‘successful’ but ideas of ‘success’ in Western cultures often denote ideas of economic achievement, employment status and other forms of cultural / social capital that are primarily associated with white middle class values (Bartlett and Peel, 2005). These discourses also have a particular emphasis on the value of work and work-like activities in which even leisure time is framed as active and productive (Fullagar, 2002; Estes *et al.* 2003). ‘Healthy’ ageing is further seen to prioritise health over all other dimensions of later life and may exclude people who experience ill-health and disabilities (WHO, 2002). One difficulty in relation to advancing policies about ‘active’ and ‘positive’ ageing therefore results from not having a consistent underlying theme for defining the concept (Bartlett and Peel, 2005).

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<sup>6</sup>. For example, two publications *Better Health in Old Age*, (DoH, 2004a) and *Choosing Health. Making Healthy Choices Easier* (DoH, 2004b) were published in the same week suggesting that the needs of older people, whilst not completely disregarded, were different and specialised.



The adoption by the WHO (2002) of 'active' ageing aims to convey a more inclusive message that widened the concept from health policies associated with individual and population ageing. The United Nations Principles of independence, participation, dignity, care and self-fulfilment are embraced. The 'passive' needs-based approach to strategic planning is replaced by an 'active' rights-based approach that, for example, promotes equality of opportunities and treatments as people grow older. The WHO definition of health as physical, mental and social well-being is central to this concept. Whilst these are important concepts to promote within the WHO's vision to improve the quality of life for all people as they grow older, the WHO recognises the enormity of their vision by identifying key challenges that face ageing populations. These include the global burden of disease, increased risk of disability, providing care, the feminisation of ageing, ethics and inequities (such as, dilemmas in relation to: end of life care, human rights for disabled and poorer older people, long term care, scientific developments, advanced modern medicine, and anti-ageing claims and treatments) and economic concerns due to the possibilities of increased health care and social security costs. It can therefore be seen that the key motivators behind policies of active ageing predominately focus on concerns related to ill-health, the provision of health care and the nature of the ageing body.

And herein lies the problematic at the heart of the concept of active ageing. How do you marry the promotion of ageing as a time of possibilities and opportunities with the inevitable onset of decline, deterioration and decay of an ageing body? For two alternative discourses are evident within the concept of active ageing (cf. Shilling,

1993; Bury, 2000; Katz and Marshall, 2003; Williams, 2003). The first ‘positive’ image conveys the possibilities and opportunities of later life, the good life here and now, and the pleasurable pursuits and consequences associated with body maintenance regimes, such as, diet and exercise. Alongside the promotion of health, activity, vitality and well-being are wider concepts associated with self-care (Bernard, 2000), ‘empowerment’ and personal responsibility (Katz and Marshall, 2003) that enhance our sense of citizenship and communities. As Petersen and Lupton (1996) argue discourses of the new public health are directed towards ‘making up’ certain kinds of individuals. At the same time, to ensure that individuals both engage with health promotion discourses and are vigilant about their body maintenance regimes a sense of fear associated with ageing, decay and death also needs to be instilled. These more ‘negative’ images are associated with perceptions of heightened risks to health, bodily vulnerabilities and dependence associated with growing older.

At the core of active ageing are therefore ‘prescriptions about how we should live our lives and conduct our bodies, both individually and collectively’ (Petersen and Lupton, 1996, p. 174). Surveillance and monitoring strategies utilised by the new public health, such as epidemiology, statistical surveys and risk management, further construct boundaries between ideas of ‘normality’ and ‘pathology’ in later life (Petersen and Lupton, 1996; Katz, 1996). Two alternative images of ageing in health discourses (Higgs, 1998) map onto the moral constructs (Hepworth, 1995) between the ‘normalised’ image of ageing associated with activity and health and the ‘other’ pathologised image of ageing as a time of frailty and dependency. Moreover, the tendency in policy and research to focus on the ‘negative’ portrayals of ageing, such



as, ill-health, dependency, care, falls, mental health, safety in the home and other perceived social problems with ageing (Ginn and Arber, 1995; Bury, 1995; Ballinger and Payne, 2002; Victor, 2005) inadvertently pathologise old age by enhancing these connections with ill-health, dependency and decline. Old age is increasingly constructed as a time of high risk.

The promotion of active ageing reflects a tendency for both lay and expert discourses to increasingly use the notion of risk (see Giddens, 1991, 1998; Davison *et al.*, 1991, 1992; Beck, 1992; Williams and Bendelow, 1998; Lupton, 1999; Tulloch and Lupton, 2003) that increasingly focus attention on the ageing body. For the concept of risk is central to the way older people conduct their embodied selves (Petersen and Lupton, 1996). As Higgs argues the ‘imagery of risk is incorporated into the practicalities of everyday life ... health promotion steps into the public domain as a virtuous activity not only promoting health but also the person’ (1998, p.193). Through ‘technologies of the self’ people are encouraged to take more and more personal responsibility for their health and to extend their period of activity into their third age. However, physical limitations and the inevitable decline of the body ultimately restrict choices regardless of any technologies of the self. Paradoxically, the image of ageing in health discourses of dependency and frailty can ultimately move all older people into their own category of risk rather than being viewed as active participants in risk discourses.

There is however limited empirical research into how policies of active ageing interact with people’s own ideas of risk, health and ageing in their everyday lives.



This chapter will now turn to the ideas of Beck and Giddens in order to consider the significance of ‘risk’ and ‘reflexivity’ in the context of older people’s social worlds.

### **Healthy lifestyles, ‘risk’ and ‘reflexivity’**

A heightened awareness of risks <sup>7</sup> is for Beck (1992) and Giddens (1984,1991) a distinctive feature of reflexive modernity. As we move away from tradition the notion of risk becomes an important aspect of the ‘colonisation’ of the future. Risks, with the associated uncertainties of an unknown but anticipated future, are key factors in the way people organise their lives. For Giddens (1991), in an era of heightened reflexivity, ‘risk profiling’ is a central principle through which people construct their lifestyles, self-identities and bodies as ‘reflexively organised projects’.

It is through a continual process of questioning and reordering self-narratives that a person constructs their own identity, and as part of this process adopts a chosen lifestyle, or a ‘relatively integrated set of practices’ (Shilling, 1993, p.181). It is in this context that lifestyle choices can be negotiated. The self and the body are not ‘given’ but are reflexive projects. However, as a person attempts to make lifestyle choices from a diverse number of options there is, at the same time, a chronic revision of all knowledge and practices. Paradoxically whilst we have become increasingly reliant on ‘abstract’ knowledge systems of expertise in order to obtain a sense of ‘ontological security’, now experts frequently disagree with one another and ‘even

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<sup>7</sup> Whilst Beck and Giddens both refer to risk as a hazard and/or danger, there are differences in their perspective (see Lupton,1999). The heightened reflexivity surrounding risk is for Beck a response to more risks in contemporary societies. In contrast, for Giddens, the nature of subjectivity has changed so that we perceive that risks are greater. Giddens also adds the dimension of active trust in relation to risks and reflexivity.

the most reliable authorities can only be trusted “until further notice” (Giddens, 1991, p.84). It is therefore in the context of radical doubt that people make lifestyle choices which requires an active trust of the chosen expert system (Giddens, 1991; Williams and Calnan, 1996).

As ‘risk profiling’ is a key feature of expert knowledge systems an ‘awareness of risk seeps into the actions of almost everyone’ (Giddens, 1991, p.112). Health promotion clearly illustrates how this occurs (Giddens, 1991). First, as a discourse of risk, health promotion demonstrates the link between reflexivity in everyday lives and extrinsic risk. Second, health promotion discourses signify the interaction between expert knowledge systems and the adoption of lifestyles by the lay populace. However, as Lupton (1999) argues, underlying the concepts of ‘risk’ and ‘reflexivity’ is the notion of the ‘rational, calculating actor’ who chooses between different risk factors defined by expert knowledge systems. So whilst the process of reflexivity is practised in people’s intimate and everyday social worlds, it is the interaction between the expert and lay knowledge systems that is privileged. There is therefore limited recognition about how older people develop understandings of risk within their everyday lives.

Significantly empirical evidence suggests that lay knowledges are more complex and contradictory than suggested by Giddens and Beck (Gabe, 1995; Lupton, 1999). People do not only negotiate their lifestyles in relation to ‘risk’ as defined by experts, but base their decisions on many factors. These include their own personal life experiences, the mediation of knowledge by other lay actors (Davison *et al.*, 1991,



1992; Lupton and Chapman, 1995; Lupton, 1999; Tulloch and Lupton, 2003) and their own lay logic, for example, in terms of ‘fate’ and ‘luck’ (Davison *et al.*, 1991,1992) and ‘misfortune’ in the context of accidents (Green, 1997). Lay people are further critical of and ambivalent about the contradictory and conflicting messages of experts in health promotion (Lupton and Chapman, 1995; Wynne, 1996) that frequently involve a complex interplay between expert and lay discourses of risk (Green *et al.* 2002). The construct of people as risk averse can also underplay pleasures of voluntary risk-taking due to the heightened intensity of emotional and bodily sensations (Lupton and Tulloch, 2002a). Crawford points to these discourses in terms of opposing notions of ‘control’ and ‘release’ associated with health (Crawford, 1984). Moreover, not all lifestyle choices are reflexive, but may be due to habit (Lupton, 1999) and are therefore hardly thought about at all (Williams, 1995).

Perceptions of risk are also socially and culturally produced, dependent on context and further influenced by factors such as gender and age (Lupton, 1999; Lupton and Tulloch, 2002b). In particular, Giddens and Beck have been criticised for not addressing the interplay of ageing, embodiment and ‘reflexivity’ within their analyses of ‘high modernity’ (Riggs and Turner, 1997). Turner argues that ageing is an important illustration of our vulnerabilities: ‘While age as a system of social classification and aging as a social process are culturally defined, the physical consequences of the aging process are inevitable’ in which ‘human beings are biologically frail, socially vulnerable and politically precarious’ (2004, p. 185/6). People manage their sense of embodied vulnerabilities, “ontological security” as described by Giddens, through the development and maintenance of everyday

routines. Daily routines and norms can however be frequently and unpredictably disrupted due to greater exposure to physical and social risks as we age, such as, illness, disease, and social isolation. As we grow older the taken-for-grantedness of our embodiment may be increasingly challenged as we experience more and more of these bodily betrayals within our lives.

There is limited empirical research to draw upon that focuses on older people's daily lives, but it has been shown that people's position in the life course may be significant to the degree of risk-taking and risk avoidance experienced (Lupton and Tulloch, 2002b). Whilst youth was constructed as a time of high risks, this tendency changed when family and other responsibilities gained prominence in the participant's lives, evidenced by greater risk avoidance. In contrast to the orthodoxy of old age as a time of prudence, older people felt a need to be less cautious in later life as their responsibilities had lessened <sup>8</sup>. Fairhurst (2005) has also explored 'ordinary' as opposed to 'expert' ideas about age and ageing. Whilst experts view physical health, well-being and public health as discrete categories, individuals connect these matters, in relation to their own thinking about age and ageing. For example, whereas stairs are constructed as a potential source of danger in professional discourses, due to perceived risks of falling, older people viewed the stairs as a source of exercise that promoted their well-being. These examples of empirical research suggest that ideas of risk and reflexivity are complex when situated in people's everyday worlds.

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<sup>8</sup> The results of a pilot study reported by Tulle-Winton (1999) also emphasise the willingness of older people to take risks.



Williams (1990) has further shown how moral dimensions of discourses about health in later life map onto a distinction between early and late old age. Whilst older people recognised and were resigned to the decay, deterioration and frailty of the body associated with late old age, they believed they had a ‘moral duty’ to delay the onset of ill-health. To remain healthy was seen as a moral enterprise that involved an obligation to remain active and take precautions against the inevitable process of ageing and ill-health in late old age. The distinction between different categories of ‘old’ may therefore also be significant, as the ability to make different choices and engage in a multiplicity of lifestyles, may predominately only be relevant to the image of old age as a time of activity and health (Higgs, 1998). The idealised images of older people as timeless and ageless consumers of health and lifestyles are moreover frequently linked to the culture of consumerism.

### **Consumer culture and images of ageing**

The proliferation of images associated with ‘positive’ ageing is predominately associated with the culture of consumerism (Featherstone and Hepworth, 1990, 1995a,b; Featherstone, 1995; Featherstone and Wernick, 1995; Katz and Marshall, 2003). Within this post-modernist perspective, ageing has become a more fluid process, signified by the deconstruction of the life course. In recent years, the significance of chronological age as an indicator of generational ‘norms’ and ‘lifestyles’ has become discredited resulting in a blurring of different life stages, for example, between middle and old age. This is illustrated by the sudden increase in new demographic terms for mid to later life such as “baby boomers”, “third agers”,

and “new middle agers” (Katz and Marshall, 2003) that involves life before and after retirement (Fairhurst, 2003b). New lifestyles, identities and bodily styles abound and have given ageing new symbolic and cultural meanings that portray the ‘new antiageist, positive senior as an independent, healthy, sexy, flexi-retired “citizen”, who bridges middle age and old age without suffering from time-bound constraints of either’ (Katz and Marshall, 2003, p. 5). Within post-modern cultures timelessness, impermanence and simultaneity are central (Katz and Marshall, 2003).

The body is no longer a “given” in the culture of consumerism and is less restricted by previous limits and constraints (Shilling, 1993) in which the ‘ageing body is rapidly becoming a key element in the post-modern uncertainty over what constitutes natural’ (Gilleard and Higgs, 2005a, p. 119). There has been a proliferation in images associated with anti-ageing and aesthetic aspects of bodies, for example, cosmetic surgery, anti-ageing technologies, such as bio-ageing, lifestyle changes, such as nutritional / exercise regimes, and anti-ageing cosmetics, creams and other products (Gilleard and Higgs, 2000, 2005a). Older people are constructed as active consumers who can make choices about how they engage with the ageing process. These techniques and technologies are however not without risks:

*While cosmetic surgery exploits the possibilities of surgical technology to re-aestheticize the ageing body in one swift act, it remains a private and risky enterprise that currently possesses a rather limited social value. Consumption of over-the-counter medicines and all the various ‘anti-ageing’ cosmeceuticals and nutraceuticals offers a less risky strategy but requires*



*sustained lifestyle changes with little obvious to show for them*

(Gilleard and Higgs, 2005a, p. 119).

Bodily boundaries are not only fluid, risky and uncertain but the body has increasingly become the focus for display and signification in the consumerist market of desire.

The extremes of the post-modern vision are encapsulated within ideas of aspirational science and science fiction, anti-ageing medicine and the possibilities of ‘posthuman’ bodies (Katz and Marshall, 2003). The fluidity of bodily boundaries associated with technological expertise such as, cyborgian prosthetics, computer-generated virtualities, robots, and data driven commodity forms, have the potential to reconstruct the limits of human life (Katz and Marshall, 2003). The claims and techniques of (predominately private sector) anti-ageing medicine, such as, prophylactic high-technology surgery, also thrive in a post-modern culture. However, the predictions of anti-ageing science and medicine could just as easily be seen as a continuation of ‘modernist’ ideals that aspire to ‘triumph over nature’ (Gilleard and Higgs, 2005a; Vincent, 2006). The underlying association between old age and ‘biological failure’ within these anti-ageing technologies further enhances a cultural construction of old age as bodily decline: it is therefore the interplay of the technological with the cultural that is central (Vincent, 2006).

The body is nonetheless an integral part of consumer culture that ‘latches onto the prevalent self-preservationist conception of the body, which encourages the individual to adopt instrumental strategies to combat deterioration and decay’

(Featherstone, 1995, p.170). Dietary, exercise, slimming and cosmetic body maintenance products signify the current fascination in bodily appearance and preservation. The proliferation of anti-ageing products highlights the significance of the bodily values celebrated in consumer culture: youth, 'body beautiful', health, vitality, self-preservation and body maintenance. The body conceptualised within consumer culture does however have two dimensions: an inner and an outer body. The inner body denotes concerns about health, optimum bodily functioning and body maintenance. The outer body refers to the aesthetics of the body, bodily appearance and the way the body moves and is governed in social space. These two images have moreover become conjoined in consumer culture as the 'prime purpose of the maintenance of the inner body becomes the enhancement of the outer body' (Featherstone, 1995, p. 171). The body is therefore not only a vehicle for pleasure and self-expression but has become symbolic of the self. Whilst the virtues of diet and exercise are seen as ways to achieve a more exciting life as well as an enhanced sense of well-being, bodily neglect can lower self-esteem and even lead to accusations of laziness and moral failure. "Body work" becomes 'the passport to all that is good in life' (Featherstone, 1995, p.186) and "free time" increasingly becomes transformed into "body time" (Faircloth, 2003).

Images of health and ageing have moreover become intertwined within the culture of consumerism. As Featherstone argues:

*Preventative medicine offers a similar message and through its offshoot, health education, demands constant vigilance on the part of the individual who has to be persuaded to assume responsibility for his (sic) health,*



*introducing the category 'self-inflicted illness', which results from body abuse (overeating, drinking, smoking, lack of exercise etc.), health educationalists assert that individuals who conserve their bodies through dietary care and exercise will enjoy greater health and live longer*

(Featherstone, 1995, p. 183)

The impetus behind the health education movement is to change the moral climate to ensure that individuals take more and more responsibility for their own health, bodily appearance and body shape. Health education promotes a culture in which individuals are to assume self-responsibility for their body and health. It is unsurprising therefore that consumer culture only has contradictory solutions for the inevitable onset of decline, deterioration and ill-health associated with ageing (Shilling, 1993; Featherstone, 1995), for experiences of ageing impinge on two pivotal areas of imagery within consumer culture: the body (that is in decline) and time (that is limited) (Biggs, 1993). The key momentum behind consumer culture is to maintain the illusion of the good life here and now, to portray pleasurable pursuits of body maintenance, that focus on the possibilities of timeless youth and everlasting vitality: images of ageing bodies need to be distanced and hidden from public view. As Hepworth argues, the 'look of age' is 'considered unwelcome and undesirable' (2000, p. 40). At the same time, consumer culture needs to instil a fear of ageing, decay and death to ensure that individuals not only continue to be vigilant with their body maintenance regimes but continue to endlessly purchase anti-ageing and other aesthetic products.

Imageries are therefore central within consumer culture (Faircloth, 2003). Visual and textual images are important as they signify how phenomena are defined and understood within contemporary societies and may convey cultural and social fears associated with growing older (Howson, 2004). There has recently been a notable increase in research about imageries and ageing. For example, there has been research into fictional representations (Hepworth, 2000; Johnson, 2004), popular culture (Blaikie, 1997, 1999; Bytheway and Johnson, 1998; Bytheway, 2003), art (Blaikie and Hepworth, 1997; Wainwright, 2004; Abastado, *et al.* 2005); consumer images (Featherstone and Wernick, 1995) and portrayals of ageing in magazines (Featherstone and Hepworth, 1995b; Bytheway and Johnson, 1998), newspapers (Bonnesen and Burgess, 2004; Rozanova, 2006), films (Markson and Taylor, 2000; Markson, 2003), advertising campaigns (Lee *et al.*, 2007; Williams *et al.*, 2007) and on television (Kessler *et al.*, 2004). Systematic research into images of ageing in the mass media is more recent and it is generally agreed that older people are underrepresented (Lee *et al.*, 2007), in particular, images of advanced old age (Kessler *et al.*, 2004). Media and cultural portrayals also frequently draw upon negative and biased stereotypes of older people (Blaikie, 1999; Kessler *et al.*, 2004) although some change has been documented with more positive and diverse images of ageing now being portrayed (Williams *et al.*, 2007). There are two significant themes within the research into cultural and media representations of older people: (1) the interplay of ageing, gender and social class; and (2) alternate images of 'positive and 'negative' ageing.



The gendered nature of representations of ageing has been shown. The limited visibility of older people in the mass media has been documented with older women particularly underrepresented (Lee *et al.*, 2007; Kessler *et al.*, 2004). Gendered stereotypes are also evident. Markson and Taylor (2000) conducted content analysis of the type of film roles portrayed by 'notable' performers when aged 60 years and over<sup>9</sup>. It was revealed that while men were more likely to be shown as energetic, employed and involved in adventure (as a hero or villain); women tended to have peripheral roles, such as rich dowagers, wives / mothers, or lonely spinsters and were portrayed predominately as stubborn, powerless and self-sacrificing. Men were also more likely to play scenes of intimacy (often with younger women). Blaikie (1999) further highlights the desexualisation of older women in popular culture who are frequently subject to negative judgements about their physical appearance whilst older men are represented as distinguished, powerful and wise. Not only do older women rarely have sex lives in media portrayals but older people are frequently shown in traditional gender roles on prime time television series (Kessler *et al.*, 2004). These representations further reflect gendered stereotypes of 'powerful men' and 'caring women' especially in terms of socio-economic status: whilst men are in well paid jobs and reciprocal relationships, women are predominately unskilled workers and / or with significant roles caring for others (Kessler *et al.*, 2004). In this context, gender, ageing and social class can be seen to interconnect (cf. Blaikie, 1999; Howson, 2004) in media and cultural images.

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<sup>9</sup> The identification of performers as 'notable' resulted from at least one Academy Award (Oscar) nomination in their lifetime. 3,038 films were selected from between 1929-1995 and 8% of these films were analysed.

Media and cultural representations of ageing further reflect alternative images of 'positive' and 'negative' ageing. Featherstone and Wernick (1995) explored images of people portrayed in American retirement magazines. Representations of older people in the magazines were predominately affluent, attractive and 'younger' looking models who reflected an extended 'middle' age rather than 'old' age. These positive images conveyed the possibilities of new ageing identities associated with an active retirement and financial independence. Alternatively more 'negative' images of old age are also evident in the mass media. For example, Bytheway and Johnson (1998) examined visual images of later life in UK magazines and showed that alongside the positive images of ageing as a time of health, vitality and activity, there was a second image that instead conveyed old age as a time of dependency and decline. Associations with 'old' were achieved by focussing upon bodily features as 'old' and the portrayal of certain signifiers of old age, such as, mobility aids.

Rozanova (2006) explored newspaper representations of health and illness among older people that reflected the alternative 'positive' and 'negative' images evident within the concept of active ageing. In particular, there was a moral dimension to the newspaper articles for ill-health in later life was not described in terms of biological bodies but as a reflection of an older person's character. Whilst the importance of embracing healthy lifestyles was emphasised as a means to prolong health, be active, and experience longevity, in contrast, people who made unhealthy lifestyle choices, such as, a poor diet, smoking and infrequent exercise, were criticised for showing a lack of responsibility for their own health and wellbeing. These imageries of ageing can further marginalise certain groups of older people:



*By praising healthy aging, the media may, perhaps inadvertently, perpetuate new ageist stereotypes that marginalize vulnerable adults who fail to age healthily, and downplay the role of social institutions and structural inequalities (particularly gender and socio-economic status) in influencing individuals' personal resources and lifestyle choices*

(Rozanova, 2006, p. 111)

As Tulle-Winton argues, an exploration of discourses reveals how 'successful' ageing 'is recast in a framework of obligations for social actors to avoid social and cultural segregation, thus seeming to act as both a goal and an evaluation of later life' (1999, p. 282). Newspaper portrayals that emphasise the significance of individual responsibility for 'healthy' ageing may therefore underplay the significance of other factors that influence the health experiences of growing older.

Imageries of ageing therefore highlight the extent to which culture is saturated with concepts about age and ageing. As Gullette (1997, 2004) argues "we are aged by culture". Distinctions between 'us' (the 'young') and 'them' (the 'old') (de Beauvoir, 1970) are not therefore morally neutral and denote bodily differences in which young bodies are seen to have higher symbolic value than old bodies (Faircloth, 2003; Twigg, 2004). These negative imageries can be internalized so that from an early age we learn to feel bad about growing older and start to compulsively examine our bodies for signs of any decline and decay (Twigg, 2004). In contemporary western societies age has become an increasingly significant determinant of cultural and social value; however, paradoxically the more we age, the less social and cultural value we have (Gullette, 1997, 2004). The meanings and experiences associated with

growing older are therefore not only the consequence of the biological processes of ageing and are also contingent on the social and cultural milieu in which we live.

Whilst cultural factors are significant it is important not to underestimate the significance of social and structural inequalities that impinge on older people's health, well being and quality of life (Arber, 2006). Limited material resources and lower socio-economic positions have been directly linked to higher levels of ill-health, disability and death (for example: Townsend and Davidson, (1982) *The Black Report*; DoH (1995) *The Acheson Report*; Shaw *et al.*, (1999) *The Widening Gap*). Significant constraints within older people's lives have been highlighted in structured dependency perspectives of later life that link old age to lowered socio-economic positions, in particular, to high levels of material deprivation and poverty (Walker, 1981, 1987, 1993; Estes, 1986, 1991; Gunnarsson, 2002; Estes *et al.* 2003; Walker and Foster, 2006). The link between ill-health and material deprivation in old age has been shown (Arber and Ginn, 1991, 1993; Arber and Cooper, 1999) and older people with limited material resources not only experience health more negatively but have higher levels of chronic illnesses. Material and social inequalities in later life have further been linked to gender and marital status, with older divorced men and women now experiencing particularly precarious financial positions (Arber, 2004, 2006). Structural factors, such as social class, gender, marital status and ageing, therefore interconnect to shape people's experiences of (ill) health and well being in later life. Whilst there is evidence that the socio-economic position of older people is improving, with increased opportunities to be active consumers in later life (Gilleard and Higgs, 2000, 2005a,b), it is important to appreciate the number of older people



who still live in poverty (Scharf *et al.* 2006; Burholt and Windle, 2006), and therefore do not have the same material and personal resources to engage in active consumerism.

Whilst there has been an increasing interest in researching imageries of ageing there is a tendency for research to separate representations of ageing from people's everyday lives. Faircloth (2003, cf. Howson, 2004), for example, defines two distinct themes within the emergent research about the ageing body. The first theme relates to the personal and social significance of imagery, including visual representations, advertisements and media images. The second theme relates to the everyday experience of the ageing body and focuses on the mundanity of the "lived body", and the meanings and experiences of bodies in daily life. Research that focuses on representations in the media is however unable to inform us about how people negotiate their social identities in the context of their daily lives.

Fairhurst (2003b) has criticised research on emergent lifestyles and identities for almost exclusively drawing conclusions from either media images focussing on middle (rather than old) age or extrapolating from statistical data. This research has neither started from the perspective of older people themselves nor been grounded in people's everyday lives. There is therefore limited research into the interconnections between images of ageing and people's lived experiences or the ways in which older people negotiate their social identities in the context of alternative images and discourses around positive (*active* / freedom / fluid) and negative (*passive* / dependence / decline) ageing (cf. Calasanti and Slevin, 2001). This is despite

increasing awareness how images, discourses and stereotypes of old age might 'mask' the diverse and intense personal experiences of people as they grow older.

### **Masking theories and experiences of ageing**

The link between collective imageries and stereotypes of ageing with people's identities and experiences in later life has been captured within masking theories that have gained prominence in recent years. Whilst masking theories differ analytically they do share the ideas that as people grow older (with a notable focus on middle and early old age) that they are likely to resist bodily changes associated with ageing that significantly restrict their opportunities for everyday self-expression in public. The diverse and intense experiences of later life may therefore be hidden. Within these debates the metaphor of the 'mask' can be seen to operate analytically in two distinct ways: (1) ageing as a process, and in particular, the ageing body masks (hides) an inner (more youthful) self; and (2) the wish to mask (disguise) the ageing process itself (Ballard *et al.* 2005).

The first analytical stance of the 'mask' of ageing is evident in the postmodern analysis of Featherstone and Hepworth (1990, 1995a, 1998) in which old age 'is defined as a mask which conceals the essential identity of the person beneath' (Featherstone and Hepworth, 1995a, p.379). The ageing body disguises a more youthful inner self and in consequence conceals the subjective identities, feelings and meanings important within the everyday lives of older people. Bodily signs of ageing, such as, wrinkles and greying hair, in due course become a 'mask' that cannot be removed. So whilst an inner sense of youthfulness remains, this becomes increasingly



problematic for people as they grow older, as they increasingly experience a constant tension between the expression of socially appropriate emotions and behaviours of old age, whilst suppressing their own private, subjective, and intense feelings and identities (Hepworth, 1998). The ‘mask’ of ageing is therefore seen as central to people’s experiences of growing older:

*At the heart of the difficulty of explaining what it’s like to be old lies the awareness of an experiential difference between the physical processes of ageing, as reflected in outward appearance, and the inner or subjective ‘real self’ which paradoxically remains young*

(Hepworth, 1991, p. 93)

This idea of the ‘mask’ highlights the significance of interconnections between the ageing body, the social and the subjective self. Due to negative qualities attributed to ageing in contemporary societies older people learn to act ‘old’ and behave in socially appropriate ways. At the same time older people are performing in the context of social interactions with others who themselves are responding to the visible actions and bodily appearance ‘given off’ by older people. An ‘aged identity emerges’ (Ballard *et al.*, 2005) and the ‘mask’ of ageing (i.e. the ageing body) increasingly becomes an ‘iron cage’.

Alternatively the ‘mask’ metaphor has been drawn from a psychodynamic perspective as a way to protect the self from an ageist and uncertain social world. Concepts of mask motifs in this context include ideas of ‘masquerade’ or hidden identity (Woodward, 1991) and ‘persona’ or ‘social mask’ (Biggs, 1993, 1997, 2004). Woodward focuses on the active creation of a social disguise to obscure social and

bodily signs of ageing: ‘both men and women “put on” youth so not as to be classified as old’ (1991, p. 159). Masquerade involves both concealment and pretence and can be seen as an expression of ageing; however paradoxically acts of concealment may inadvertently draw attention to signs of ageing.

For Biggs (1993, 1997), the persona acts as a bridge between the social and the personal: ‘personae are essentially social phenomena, coping strategies to maintain identity, depending on different material, including bodily contexts ... a device through which an active agent looks out at and negotiates with the world, to protect and deceive’; social masking is a ‘means to acceptable self presentation in interpersonal contexts’ (Biggs, 1997, p. 559). The social mask in later life acts as a device to protect the self whilst deceiving others. Subjective and bodily experiences are conjoined in social masking theories (Ballard *et al.*, 2005). Bodily changes associated with ageing, such as greying hair and wrinkles, prompt people to reflect on their personal identity and identify with their ageing body. However, social pressures to conform to circumscribed ageing identities result in the development of cultural identities and social masks in order to maintain a socially acceptable image and lifestyle in public: the inner identity remains hidden and self expression restricted. It is therefore the social world that is primarily conceptualised as a threat to a person’s sense of identity in later life (Ballard *et al.*, 2005).

Despite the different analytical approaches masking theories do share important ideas. First, masking theories focus on the interconnections between the ageing body, the subjective self and the social in later life and further highlight the embodied nature of



ageism. The consequences of the embodiment of ageism are that as people grow older they increasingly engage in age resistant activities. The pressures of ageism result in the creation of social disguises, the changing of bodily features, such as, hair colour, and / or the maintenance of a youthful inner image. People's ultimate objectives are however to distance themselves from 'deep old age' So whilst consumer society challenges traditional notions of ageism and offers new ways and possibilities to age associated with newly emergent lifestyles, identities and opportunities, at the same time consumer culture has created newer (and often more subtle) forms of ageism (Öberg and Tornstam, 2001; Calasanti and Slevin, 2001; Gilleard and Higgs, 2005a). The desire to remain ever young can undermine older people's self confidence and result in self-imposed limitations and expectations (Gilleard and Higgs, 2005a). These ageist discourses are especially problematic for people experiencing ill-health, care, disability and deep old age (Twigg, 2004). Feminist analyses have further highlighted how the interplay of ageism, sexism and commercial interests results in more women consuming age resistance products and services than men (Calasanti and Slevin, 2001; Ballard *et al.*, 2005).

Second, masking theories have drawn attention to the limitations on older people's opportunities for self expression. Intense and meaningful feelings, beliefs and attitudes of older people are rarely revealed. The predominant dualist nature of emotions between the social (outer) and the subjective (inner) have two significant outcomes for older people's experiences and expressions of emotions:

*Limitations in the range of social imagery available may impede the expression of subjective feelings, or secondly, private individuals may wish to*

*conceal their personal feelings from public view and concentrate their energies on producing passable performances of the emotions that they have come to believe are socially acceptable*

(Hepworth, 1998, p. 174)

Subjective emotions behind the ‘mask’ of ageing may therefore necessitate a considerable amount of emotional labour. Through analysis of literary narratives of ageing Hepworth suggests that many emotional experiences, so poignantly recalled, have their point of reference in the past, at a time when the author inhabited a younger body. The prominence of reflective and reminiscent narratives of emotions may, however, have been due to the method and the intrinsic nature of literary texts.

Social values portrayed in representations of older men and women may not however always be synonymous with people’s subjective experiences of growing older (Fairhurst, 1998). Empirical research has indicated that when situated within people’s everyday worlds experiences of age and ageing are complex and can both reflect and resist the dominant discourses of ageing. In particular, findings from empirical research suggest that our understanding of masking theories could be enhanced in the following areas: (1) emotional experiences and later life; (2) interactions of body / self, body / mind dualisms; and (3) growing older in gendered bodies<sup>10</sup>.

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<sup>10</sup> Biggs (2004) has recently considered the interplay of gender with social masking in published narrative (not primary) research.



There is a dearth of empirical research to draw upon that focuses on emotional experiences of later life <sup>11</sup>. However, the significance of a continuing and immediate sense of emotional self has been described by older people. A qualitative study by Riggs and Turner (1997), for example, showed how older people described the significance of social relationships, intimacy and an ‘authentic’ emotional life for their health and personal development. The focus of the study was on the reflexive nature of intimacy in later life, so that the meanings that older people associated with an ‘authentic’ emotional life were not expanded upon. Lupton (1998) researched people’s own biographies of emotional experiences and the meanings and understandings associated with emotions at a variety of chronological ages. Generational and gender differences between the participants were evident. It was generally agreed that men and women were socialised differently in emotional expressions and men were required over time to learn more openness and vulnerabilities in relation to emotions. A ‘generational difference, however, emerged at various points, particularly in relation to older people of both sexes being less likely than younger people to champion the “open” expression of emotion’ (Lupton, 1998, p. 70). A tension between the experience and expression of emotions for people in mid to later life was therefore evident (cf. Williams 2001).

Empirical research further shows the interactions of body / mind, body / self dualisms within people’s accounts of growing older. Cunningham-Burley and Backett-Milburn

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<sup>11</sup> This is not to overlook the literature on depression and later life. However, as Godfrey and Denby (2004) argue there are very few studies that focus on experiences of depression amongst older people. A limited number of studies highlight the perceptions of informal carers about the depressive symptoms they experience. See Godfrey and Denby (2004) for a full account.

(1998) explored men and women's perceptions of health and health promotion in the middle years and show that as people grow older: 'The body, one's own body, in some ways becomes separate and alienated: it has nothing to do with how one feels as a person: yet may still have a lot to do with how one *feels*'<sup>12</sup> in a physical and / or emotional sense' (Cunningham-Burley and Backett-Milburn, 1998). It is argued that bodily changes over time increase the awareness of the body within the mind. The separation of the body and mind in midlife has also been highlighted by Fairhurst (1998) who shows how boundaries between the body and mind are constructed in and through the use of language. Öberg distinguishes between experiential and expressive aspects of the ageing body: whilst older people who experience frequent 'bodily betrayals' may dissociate from their body as a coping strategy; other older people may 'feel they can present themselves in a desired way through their (expressive) body' (1996, p. 714).

Empirical research into perceptions of physical attractiveness as people grow older has also highlighted the significance of the gendered nature of later life. Furman (1997) conducted an ethnographic study of older women who were regular customers in a beauty salon in America. Gender and ageing intersected within the beauty salon as women created a 'moral' and caring community and freely shared talk about their bodily experiences, for example, their double chins, wrinkles, and aches and pains. At the same time feelings of shame and disgust were also associated with their experiences of their ageing bodies:

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<sup>12</sup> Emphasis in original.



*The cultural values that have shaped their moral identities often make such women feel like moral failures, weighted down by guilt, shame or the experience of insufficiency: for having wrinkles, for not being thin enough, or for their inability to continue caregiving tasks*

(Furman, 1997, p.167)

Older Jewish women's bodies were culturally constructed from the perspective of a male gaze, a youthful gaze: the gaze of the dominant culture. The combination of ageism and sexism devalued the experiences of the older women, especially their caring roles; and the experience of being within, that is 'being' an ageing gendered body, significantly restricted their public visibility. However, whereas in public the older women were 'other', within the beauty the salon they had created a community of selves. These findings suggest that the 'mask' of ageing may also be spatially and socially contingent as the phallic gaze, well documented in feminist writings, interacts with a youthful gaze, embodied in media and cultural imageries, and subjugates the experiences of older women (Twigg, 2004).

Fairhurst (1998) explored the ways middle aged men and women depicted bodily aspects associated with growing older. All the men and women were aware of bodily changes associated with middle age, such as, weight changes, wrinkles and greying hair. Both men and women emphasised the importance of age-appropriate behaviours and dress. There was an awareness of the link between youth and physical attractiveness, and physical attractiveness was an issue: however, 'Strenuous attempts to retain youthful appearance warranted derision' (Fairhurst, 1998, p. 263). Physical attractiveness was not shown to be the sole concern for women and an emphasis on

the importance of ‘making the best of yourself’, in terms of physical appearance, dressing smartly and enhancing an inner sense of well being, was expressed by both men and women. Whilst awareness of cultural connections between youth and attractiveness were evident, the ways in which middle aged people oriented to this cultural knowledge varied in relation to their own subjective meanings about age and ageing. For example, women who described an importance to keep young also expressed a fear of old age. Fairhurst therefore reveals the nuances of men and women’s experiences of growing older in which links between collective imageries and people’s subjective experiences of ageing were complex, gendered and socially constructed.

Ballard *et al.* (2005) draws on interviews with women in their 50s and argues that whilst women wanted to project a ‘socially acceptable image’, this did not appear to be youthful one, but instead an image that reflected their subjective sense of growing older. This sense of identity arose from the distinctions between ‘public’ and ‘private’ ageing in the women’s accounts. Public ageing denoted changes to appearance on the surface of the body, such as, increased weight, grey hair and wrinkles. These bodily changes had the potential for concealment by engaging in age resistant activities. In contrast, private ageing was less visible and arose from physiological changes within the body, such as, memory loss, tiredness, the menopause and aching joints. These bodily changes were predominately identified as irreversible markers of ageing. It was however signifiers of private ageing that increased women’s awareness of growing older and further acted as a deterrent from engaging in age-resistant activities. The research by Ballard *et al.* resonates with the with the ‘outer’ and



‘inner’ dimensions of the body described in consumer culture (cf. Featherstone, 1995) and highlights the complexity of the (in)transient and (in)visible nature of ageing bodies.

It is interesting that the majority of this research focuses on the experiences of older women <sup>13</sup>. Calasanti and Slevin (2001) argue that experiences of changes in bodies differ for men and women and it is therefore important to consider the ways masculinities and femininities intertwine with ageing bodies (see also Harper, 1997; Twigg, 2004; Meadows and Davidson, 2006). Whilst ‘hegemonic masculinity’ (Connell, 1995) emphasises ‘doing’, femininity is primarily about ‘appearance’: so that for older men discourses about the ageing body may be about performance, and for older women about how bodily changes are felt and dealt with (Calasanti and Slevin, 2001). Men may also ‘*become embodied as they age*’:

*Under patriarchal knowledge systems, while women throughout their lives cannot escape the construction of their bodies, men are enabled by this system of knowledge to deny the body for much of their lives. It is only in later life that men, like women, through the experience of the experiential and constructed body, are forced to recognize the ‘other’ as a defining force in their own construction and experience.*

(Harper, 1997, p. 169)

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<sup>13</sup> There has been an increased interest in men’s social worlds in recent years. See for example, Thompson (1994), Davidson *et al.* (2003a,b) and Meadows and Davidson (2006).

Gender may further interplay with ethnicity and social class<sup>14</sup> as people grow older. The diversity of experiences and perceptions of growing older in diverse gendered bodies would therefore benefit from more empirical research.

Masking theories have however drawn attention to the centrality of the ageing body and empirical research has further highlighted some of these embodied complexities for people as they grow older. Turner (1995) argues that reflexive projects of the self need to be understood in terms of our embodiment, that is grounded within the constraints and possibilities of the lived body as experienced in everyday life. This chapter will now consider the significance of the ageing body as we grow older.

### **Ageing, the lived body and everyday life**

Ageing studies have not addressed the question of the body until recently (Öberg, 1996; Harper, 1997; Gilleard and Higgs, 1998; Tulle-Winton, 2000; Calasanti and Slevin, 2001; Twigg, 2004, 2006). In part this omission was an attempt to move away from overly medical accounts of old age (Tulle-Winton, 2000; Twigg, 2006). Old bodies, subjected to a medical gaze, are conceptualised as distinct and rational biological entities, that can be observed and measured, and become ‘objects’ of medical expertise (Tulle-Winton, 2000, p.72). The dominance of biomedicine was however challenged by political economy perspectives that argued that experiences of older people were determined not only by biology but by structural social processes

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<sup>14</sup> Wandel and Roos (2006) have shown how age perceptions and physical activity differed between middle aged men in different occupational groups. For example, carpenters were concerned about decline in strength, engineer’s discourses focused on body shape and stress, and drivers talked about leaving the body alone and take it as it comes.



such as retirement, social class and gender (Walker, 1981, 1987, 1993; Estes, 1986, 1991; Arber and Ginn, 1991, 1993; Estes *et al.* 2003). These perspectives aimed to separate ageing from dominant discourses of ill-health and biological decline: a focus on ageing bodies was therefore viewed as a backwards step: an unwelcome return to biological determinism and narratives of decline (Twigg, 2003, 2004, 2006). Social constructionist accounts therefore gained prominence and the 'body' disappeared (Öberg, 1996; Gilleard and Higgs, 1998; Tulle-Winton, 2000).

In recent years this situation has started to change. An intellectual shift from structure, within political economy perspectives, towards agency, within cultural approaches, has opened up the possibilities for more reflexive accounts that focus on identities and lived experiences of old age (Gilleard and Higgs, 1998; Twigg, 2003, 2004, 2006). As shown in this chapter, the emergence of consumer culture, postmodern and cultural perspectives, and masking theories (Featherstone and Hepworth, 1990, 1995a; Woodward, 1991; Gullette, 1997, 2004; Gilleard and Higgs, 1998, 2000, 2005a) has brought the nature of body and self into analytic focus and:

*(A)s such, it is part of the wider Cultural Turn. This literature drives forward the earlier agenda of social constructionism, but in a more radical way, showing how the body itself is social constituted. Essentialising discourses in relation to the body need to be replaced by ones that recognize its nature as a social text, something that is both formed and given meaning within culture. The aging body is thus not natural, is not prediscursive, but fashioned within and by culture*

(Twigg, 2004, p. 60)

Cultural perspectives have therefore destabilised earlier conceptual distinctions between nature / culture, biological / social and reclaimed questions and concerns about ageing bodies that had effectively been handed over to medicine (Twigg, 2004).

There are however limitations to both biological (medical) and social constructionist (cultural) approaches. Biomedical accounts are reductionist and have the effect of objectifying and distancing old age as 'other'. The stance of the ageing body as a fixed and objective entity has, for example, been held by gerontologists for many years:

*Whether young or old, this is an objective body – a material entity with a physical presence that cannot be totally ignored .. the objective body is “there” for all to behold. It can be observed, evaluated and responded to, as one might engage with other physical entities*

(Gubrium and Holstein, 2003a, p. 206-7)

Biomedical accounts further result in the inevitable Cartesian split between body and mind (Bendelow and Williams, 1995; Williams and Bendelow, 1998). Traditional medical approaches do not incorporate the subjectivity of older people, thereby limiting the possibilities of old age, and neglect broader cultural and sociological aspects of ageing. On the other hand, radical cultural accounts present the body as discursively produced in which any basis of corporeality and physiology of the body, at least the ability to know it, are denied (Twigg, 2004, 2006). Paradoxically the privileging of discourse has reproduced Cartesian dualisms between the body and mind so evident in medical accounts (Öberg, 1996; Twigg, 2004, 2006). Masking



theories have, for example, been criticised for conceptualising a self that is separate from the body: an inner youthful self dissociated from its corporeality. Recent research has however shown, that like pain and ill-health (Bendelow and Williams, 1995; Williams and Bendelow, 1998), ageing does necessitate an analytic engagement with the corporeality and materiality of our bodies (Calasanti and Slevin, 2001; Twigg, 2003, 2004, 2006). The visible manifestations of ageing, such as, greying hair, sagging skin and reduced physical capacities, not only bring the physiology of our bodies to the fore, but illuminate limitations to the elasticity of our bodies, that are neither purely symbolic nor social constructions. The analytic reality of our corporeality is therefore difficult to evade: for whilst we are “aged by culture”, we are also aged by our bodies (Twigg, 2003).

The predominance of Cartesian dualisms have been destabilised in recent research (Leder, 1990; Bendelow and Williams, 1995; Williams and Bendelow, 1998) that focus attention on the interplay of bodily processes with the cultural and social context in which they exist (see also Williams, 2001, 2006; Shilling, 2005). In this context a number of researchers have advanced phenomenology as a way to analytically study the body (Bendelow and Williams, 1995; Leder, 1990; Turner, 1992; Williams and Bendelow, 1998; Nettleton and Watson, 1998; Tulle-Winton, 2000). Phenomenological approaches focus on the lived experiences of our embodiment. The idea of the ‘lived body’ draws on the work of Merleau-Ponty (1962) who developed a concept of human embodiment that transcended Cartesian dualisms between the body and mind (Bendelow and Williams, 1995; Williams and Bendelow, 1998; Nettleton and Watson, 1998). Merleau-Ponty argued that it is not

possible to separate human perception from our embodiment as we are not able to either perceive anything or function independently of our bodies (Merleau-Ponty, 1962; Williams and Bendelow, 1998, Nettleton and Watson, 1998). That is our corporeality is central to our being in the world; our perception of everyday reality depends on a 'lived body'. Human beings can further be seen to have a dual nature in which we both *are* a body, and we *have* a body <sup>15</sup> (Williams and Bendelow, 1998). These distinctions lead to the central ambiguities within our experiences of embodiment as simultaneously personal and impersonal, objective and subjective, and social and natural.

In this respect, our embodied experiences of everyday life are absent from view (Leder, 1990). We are not routinely noticing and directing our bodies nor are we always consciously aware of our body whilst undertaking everyday practices, such as, walking, smelling flowers or observing our visual world (Nettleton and Watson, 1998). As Leder argues:

*While in one sense the body is the most abiding and inescapable presence in our lives, it is also essentially characterized by absence. That is, one's own body is rarely the thematic object of experience. When reading a book or lost in thought, my own bodily state may be the farthest thing from my awareness*

(Leder, 1990, p.1)

Empirical research has demonstrated how the body in everyday life is taken for granted except when bodily states, such as pain and ill health, intrude on our daily

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<sup>15</sup> Nettleton and Watson (1998) make a further analytical distinction between *having* a body, *doing* a body and *being* a body.



routines and we become consciously aware of our corporeality (Bendelow and Williams, 1995; Williams and Bendelow, 1998). For as 'the process of Cartesian dualism suggests, it is only through an act of conscious reflection that the split between mind and body is effected' (Williams and Bendelow, 1998, p.2). Therefore, whilst discursively, and at moments of bodily intrusion into everyday life, a distinction between the body / mind may be emphasised, at the experiential level of our everyday bodies, the mind / body dualism is lived as an ongoing flow of experience and synthesising powers (Williams, 2003, 2006). Our lived experiences moreover both construct and are constructed by our social worlds (Nettleton and Watson, 1998). Our knowledge of our localised material worlds is mediated via our bodily senses, such as, smell, touch, praxis and desire: in this context '(T)he lived body is not just one thing in the world but a way in which the world comes to be' (Leder, 1992, p. 25). The interplay of bodily processes associated with age and ageing with the social and cultural context in which they exist is therefore central.

The 'lived body' approach can be seen as an important way forward in promoting our understanding of older people's embodied experiences. Ageing studies has however rarely engaged with research into older people's experiences of everyday life (Gubrium and Holstein, 2000) or their phenomenological experiences (Tulle-Winton, 2000). Secondary analysis of empirical research has pointed to how an exploration of the ageing body in everyday life may be significant. Gubrium and Holstein (2003a) argued that the ageing body is not an objective constant presence in everyday life but is instead an experiential entity that at times feels very noticeable and evident, a body that at times intrudes into daily routines, whilst at other moments recedes from view

(Gubrium and Holstein, 2003a). So whilst experiences of the body are variable, concurrently transient and ever-present, for older people it is the increasing visibility of an ageing body that needs to be managed and given new meanings and explanations (Gubrium and Holstein, 2003a, p. 206). Through an empirical exploration of bathing in social care, Twigg (2003) also shows how a focus on the mundanity of daily life, the ordinary and banal patterns and experiences, can elicit important insights into the texture and meanings of growing older. The significance of our embodied vulnerabilities was shown via an exploration of the bounded nature of care relationships, meanings inscribed to different parts of the body, and the tension between the gaze of youth and old (naked) bodies.

Emergent empirical research into the ageing body <sup>16</sup> has further focussed on ageing and identity in relation to specific groups, such as, retired ballet dancers (Wainwright and Turner, 2003) and veteran elite runners (Tulle, 2003). Significantly this research highlights the significance of the corporeal body, in particular, the ways people in mid to later life negotiate their social identities. For example, Wainwright and Turner (2003) analysed narratives of retired ballet dancers and showed how the body was significant to their own biographies and identities as dancers aged:

*“aging ballet dancers” trying to dance the classical roles of their “youth” is an example of the futility of ignoring the resistance of reality – the reality that*

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<sup>16</sup> There has also been a limited amount of research into body image and ageing. See Calasanti and Slevin (2001) for an overview. This research focuses on women’s experiences of body weight and ageing (Tunaley *et al.* 1999; Hurd, 2000) and youthful ideals, bodily appearance and ageing (Öberg and Tornstam, 1999; Dumas *et al.* 2005). This research mainly involves older women.



*the body is aging physiologically as well as culturally in a context that bounds its decline tightly.*

(Wainwright and Turner, 2003, p. 284)

The corporeality of the ageing body was also significant for elite veteran runners (Tulle, 2003). The practice of running was an ‘art of living’ or the ‘art of existence’ in which the runner’s body was a significant source of social capital, and central to the maintenance of an identity as a runner, despite the constraints placed on the ageing body. Whilst the majority of older people are of course not elite athletes, this research does signify the interplay of corporeal and cultural narratives of ageing, and the centrality of the ageing body to lived experiences. As Shilling (1993) argues, the body is an *unfinished* biological and social entity that can continually change, within certain limits, through participation in our everyday lives.

### **Concluding comments**

This chapter has explored the relevance of the promotion of the concept of active ageing to people’s experiences of growing older. In particular, the chapter has identified and explored a key problematic within the concept of active ageing: how do you marry the promotion of ageing as a time of possibilities and opportunities with the inevitable onset of decline, deterioration and decay of an ageing body? The ageing body was also identified as the tapestry that enabled the interplay of these images of old age that alternate between positive (*active* / freedom / fluid) and negative (*passive* / dependence / decline) imageries associated with ageing. These conclusions have however predominately emerged in the context of research that focuses on media images or extrapolates from statistical data. Moreover imageries of

ageing are frequently separated from the lived experiences of people in later life. There has also been limited empirical research that grounds these questions and issues in the context of the everyday lives of older people.

By focussing on the interplay of imageries and lived experiences of everyday lives, my research study has been able to capture meanings associated with the fluid, complex and diverse experiences of growing older in people's daily and ordinary lives. In particular, the aims and objectives of my research, emerging from the literature, were to explore:

- (1) how older people negotiated their social identities in the context of alternative images and discourses around positive (active / freedom / fluid) and negative (passive / dependence / decline) ageing;
- (2) older people's own meanings and perspectives about their lifestyles, self-identities and bodies; and
- (3) the salience and limitations to the concept of 'risk' and 'reflexivity' in the context of older people's everyday lives.

The following chapter will describe the research study that I conducted, in particular, the data collection methods and significant methodological and ethical considerations.



## 2

### The Research Study

*“The personal is political” became a clarion call, associated with the recognition of how the researcher’s own biography influenced the issues to be researched and the interpretation of research data ... The methodological canons of feminist research need to be applied to research on later life, giving older women and men a voice, taking on their own perspectives as subjects rather than objects of research*

(Ginn and Arber, 1995, p. 3)

The shift towards promoting an understanding of the subjective experiences and meanings of people in later life about their everyday worlds has led to an increasing focus on the research process itself and the ways data are collected. In particular, feminist researchers have influenced the debates around the research process, reflecting on their own roles in relation to research participants and questioning power relationships that underpin data collection and production (Oakley, 1990; Ribbens and Edwards, 1998; Mauthner *et al.*, 2002; Miller and Bell, 2002). This has led to further questions about the meanings of ‘participation’, ongoing ethical dilemmas and the relationships between researchers and participants (Ribbens and Edwards, 1998; Miller and Bell, 2002). These debates highlight the divisions between objectivity / subjectivity, public / private, rational / emotional, researcher / participant, textual / visual, embodied / disembodied and the analytic / intuitive within the research process (Callaway, 1992; Kleinmann and Copp, 1993). These wider methodological and ethical considerations were significant within my research.

This chapter focuses on the research process and data collection methods involved within the project. There are two sections to this chapter. The first section explores some central methodological considerations that researchers face when studying health, ageing and bodies in everyday life. The research design emerged from these deliberations: the data collection methods included in-depth interviews and photo-elicitation with 50 participants aged between 50 and 96 years. In the second section the actual data collection methods and my experiences of being a researcher in the 'field' are described. This section includes a reflexive account of my own personal journey as a gendered and embodied researcher.

### **Methodological considerations: ageing, bodies and health in everyday life**

Research with older people has predominately either focused on social problems of old age or, more negatively, old age as a social problem (Ginn and Arber, 1995). My starting point was however to engage directly with a diverse group of people in mid to later life in a more open way; my central concern was to learn more about people's daily lives. The rationale for this approach was that an exploration of the mundanity of everyday life, the ordinariness of daily living, that is a focus on the 'mundane inner worlds of personal meaning' (Gubrium and Holstein, 2000, p.3; cf. Twigg, 2003) can bring a researcher much closer to how older people engage with their social worlds *in their own terms*. In particular, my aim was to capture the complexities of daily life in order to achieve a more inclusive narrative of the lived experiences of people in mid to later life.



A qualitative approach was indicated. In-depth interviewing has been shown to be effective at generating data about people's everyday worlds (Nettleton and Watson, 1998; Gubrium and Holstein, 2000); lay accounts of health and illness (Williams and Calnan, 1996a, 1996b; Radley and Billig, 1996); exploring personal and social meanings and experiences (Fielding, 1993a; Gubrium and Sankar, 1994; Mason 1996; Grbich, 1999; Silverman, 2000; Gubrium and Holstein, 2003b; Rapport, 2004); hearing the perspectives of disempowered social groups (Ruth and Kenyon, 1996; Grbich, 1999) and engaging with older people (Gubrium and Holstein, 2000; Jamieson, 2002; Wenger, 2003; Kestin van den Hoonaard, 2004). In particular, my aim was for older men and women to be given a 'voice' in which their subjectivities were highlighted (Ellis and Flaherty 1992; Ruth and Kenyon, 1996) as active and critical subjects of the research (Ginn and Arber, 1995). An 'active' and open-ended approach to the interviewing enabled the concerns, ideas and perspectives of the participants to be central throughout the whole research process (Holstein and Gubrium, 1995, 2002).

At the same time many aspects of everyday life are habitual, taken for granted, and not opened up for critical reflection at all (Williams, 1995; Lupton, 1999). Habitual practices of daily living do not require deliberation when experienced as 'natural' aspects of our localised social worlds. As shown in chapter 1, the body is also taken for granted, defined by its absence from our conscious awareness, except when bodily states such as pain and ill health intrude. There are therefore methodological implications when researching the lived body: how can accounts about the meanings and experiences associated with the body be elicited, in the context of the mundane



and ordinary rhythms of daily living, a body that is predominately absent from everyday life? During an interview, for example, participants are in many ways being asked to move from a 'practical consciousness' (i.e. the 'doing' / 'being' of the body in everyday life) to a 'discursive consciousness' (i.e. talking about the body) (Giddens, 1984; Williams, 1995).

Öberg (1996) has argued that there is a tendency for the body to disappear in biographical narrative research, as the genre promotes a sense of biographical continuity expressed via a coherent and disembodied self<sup>17</sup>. In particular, Öberg criticises the notion of the 'ageless self' (Kaufman, 1986)<sup>18</sup> for not engaging with older people's corporeality. There are however variations within the theme of biographical research and the significance of social identities and experiences have been highlighted (Wainwright and Turner, 2003) in relation to turning point experiences (Strauss, 1959), biographical disruption (Bury, 1982), epiphanies (Denzin, 1989a), fateful moments (Giddens, 1991), and disrupted lives (Becker, 1997). Our selves are moreover embedded within our biographies (Holstein and Gubrium, 2000), and as our biographical selves are embodied, life stories can be seen

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<sup>17</sup> It is important to emphasise that the apparent separateness of mind/body does not however refer to distinct ontological entities but to boundaries created through language (Fairhurst, 1998). For as 'the process of Cartesian dualism suggests, it is only through an act of conscious reflection that the split between mind and body is effected' (Williams and Bendelow, 1998, p.2). Whilst discursively a distinction between the body/mind may be evident, at the experiential level of our everyday bodies, the mind/body dualism is lived as an ongoing flow of experience and synthesising powers (Williams, 2006). A methodological question about how to generate data about people's lived experiences of later life does however remain.

<sup>18</sup> The notion of the 'ageless self' can be summarised as: 'When old people talk about themselves, they express a sense of self that is ageless – an identity that maintains continuity despite the physical and social changes that come with old age' (Kaufman, 1986, p. 7). The concept of the 'ageless self' emerged from biographical research involving 60 participants aged 65 years and over. This research has been criticised for the 'illusion' of agelessness created by denying the significance of bodily (Öberg, 1996) and subjective (Andrews, 1999) change.



to open up the possibilities of eliciting insights into the unique and unexplored areas of the ageing body (Wainwright and Turner, 2003), an ageing body that is instead 'the site of biographical experience, culturally mediated and socially located' (Cunningham-Burley and Backett-Milburn, 1998, p. 142). Interconnections between the lived body and society (Wainwright and Turner, 2003) and diverse insights into people's ideas and experiences about their bodies have been elicited from research techniques, such as, biographical narratives, in-depth / semi-structured interviews and visual prompts (Nettleton and Watson, 1998). A lived approach to our biographical selves does however require the development of 'imaginative methodological advances' (Lee and Renzetti, 1993, p.513).

As Turner argues 'methodological pragmatism' is necessary when researching the body, 'the epistemological standpoint, theoretical orientation and methodological technique which a social scientist adopts, should at least in part be determined by the nature of the problem and by the level of explanation which is required' (1992, p.57). In this context, the use of visual images in in-depth interviews (Emmison and Smith, 2000; Rose, 2001; Pink, 2001; Banks, 2001; Harper, 2002; Grady, 2004) has been identified as a way to elicit insights into intimate aspects of daily lives, such as, the body, emotions and everyday life (Bendelow, 1993, 2000; Furman, 1997; Nettleton and Watson, 1998; Harper, 2002). The method of photo-elicitation, that is the use of visual images as part of the interviewing process, has for example been shown to be effective in generating data in research studies about ageing bodies (Furman, 1997), social identities (Harper, 2002), images of health, risk and ageing (Martin, 1999, 2004); and gendered perceptions of pain (Bendelow, 1993, 2000). Another benefit

with the use of visual images was also the link to my interests in engaging with the personal and social significance of imageries and representations associated with ageing. In particular, the possibility of interconnecting visual images of ageing to the lived experiences of older people was facilitated.

It is well recognised that the interview context and relationships are central to the type of data generated (Cornwell, 1984; Miller, 1998). Furman argues that to directly ask questions about ageing, especially ageing bodies, can be experienced as intrusive and intimidating: 'too close to the vulnerabilities (women) experience as they age' (1997, p. 10). Due to negative stereotypes of old age older people are not only often reluctant to talk about age and ageing (Jones, 2006) but have a tendency to devalue significant experiences, such as, widowhood (Kestin van den Hoonaard, 2005). It is, for example, notable in Kaufman's (1986) extracts of biographical narratives, that the idea of the ageless self was predominately in response to either direct questions about being 'old' or via an interview technique in which respondents were asked to describe their own image reflected in a mirror. These questions were also asked by an embodied gendered researcher much younger than her respondents. Visual images instead act as a form of 'vignette', use the third person, and avoid the necessity for direct questions (Finch, 1987; Furman, 1997; Bendelow, 1993, 2000). The interconnection of in-depth interviews with visual methods, is therefore an important way to protect the participants whilst also eliciting important insights (Bendelow, 2000) into the relationship between collective imageries and personal experiences and identities.



The significance of interviews as a form of social interaction, in particular, the nature of the researcher / participant relationships, have also been well recognized in relation to the distinction between public and private accounts of health (Cornwell, 1984). Public accounts of health refer to socially acceptable discourses of health, ‘meanings in common currency’ (Cornwell, 1984, p. 15), which reproduce and legitimate shared assumptions about the social world. Private accounts instead relate more closely to personal experiences, thoughts and feelings of participants, and are intertwined within the participant’s narratives of their daily lives and social identities, and frequently challenge public accounts. For Cornwell (1984) these different accounts of health map directly onto the researcher / participant relationship and interview style: for example, when asked direct questions in a formal interview a participant is more likely to give public accounts whilst in a more informal relationship the participant will voice private accounts in the context of relating stories.

The distinction about public / private accounts may not however be as clear as suggested. Radley and Billig argue that ‘stories may be told when giving the formal accounts, and justifications and legitimations are still in order during the private accounts’ (1996, p. 229). Public and private accounts of health may therefore be at times multidimensional and interwoven, and at others be distinct and separate. When eliciting narratives of everyday life participants often feel a need to justify rather than describe their practices of everyday life (Williams, 1995). Conway and Hockey also argue that as ill-health and old age are seen as synonymous, ‘that when older people claim to ‘good health’ during a research interview, they may also be engaging in an

act of resistance to a stigmatizing social identity' (1998, p. 471). The social and embodied context of an interview is therefore significant.

Relationships between the researcher, participant and visual images are also not unproblematic. It is important to emphasise that the term 'elicitation' within this study does not imply that responses can be 'drawn out' of a respondent or that visual images are merely tools to obtain knowledge. As Pink (2001) argues:

*It is not simply a matter of asking how informants provide 'information' in 'response' to the content of images. Rather, ethnographers should be interested in how informants use the content of the images as vessels in which to invest meanings and through which to produce and represent their knowledge, self-identities, experiences and emotions*

(Pink, 2001, p. 68)

The use of visual images is therefore a reference point, the focus of discussion between researcher and participants, in order to explore aspects of the participant's experiences and knowledge (Pink, 2001). Visual research is a 'collaborative' (Harper, 1998) and / or participatory (Schwartz, 1989) method that promotes discussion and understanding of different views and can change the traditional power dynamics within an interview. For example, participants often respond immediately to visual images, as Schwartz says, 'interviewees often responded directly to the photographs, paying less heed to my presence and the perceived demands of the task' (1989, p.152). The content of visual images therefore prompts personal meanings and stories, a multiplicity of different perceptions and interpretations, that facilitates discussion between participants and researchers and acts as a 'bridge' between



different experiences of reality within the interview context (Harper, 1998; Pink, 2001).

Photo-elicitation as part of the in-depth interviews also interconnected the separation between lived experiences of everyday life and social representations of ageing that had been evident in previous research studies (see chapter 1). The research design therefore involved the intersection of the following data collection methods:

- (1) In-depth (biographical) interviews to explore the perspectives of people aged 50 years and over about health, risk, bodies and ageing in the context of their everyday lives.
- (2) Photo-elicitation as part of the in-depth interviews to elicit insights into the social identities and experiences of the participants in the context of alternative images of ‘positive’ and ‘negative’ ageing. Visual images as a form of ‘vignette’.

The use of visual images was therefore a ‘resource’ (i.e. a method to generate data) in the research rather than a substantive ‘topic’ (i.e. the subject for investigation) (Harrison, 2002) in order to open up the possibilities of exploring the ways that people in later life negotiated their social identities in the context of alternative images of positive (*active* / freedom/ fluid) and negative (*passive* / dependence / decline) ageing.

### **In the ‘field’: data collection methods**

The data collection for this project was conducted between October 2003 and November 2004. This final section details the actual data collection methods and my

experiences of being a researcher in the ‘field’. The analytical processes and ethical considerations are also explored. This section includes a reflexive account of my own personal journey as a gendered and embodied researcher.

### The study sites

Participants were accessed via six study sites in a city in the South-East of England. This area was chosen as a diverse range of characteristics were evident within the local population and geographical areas. The city was typical of many in the South East region in that there was an original small old town that had progressively grown and was now encompassed within a city centre and ever-increasing suburbs. This was reflected in the changing demography of the local population, some people have lived in the area all their lives, and others had relocated to the city, mainly for reasons of work and / or family. There was a diverse range of socio-economic groups living in the locality, with distinct areas of both wealth and poverty. A wide range of occupations were evident that included commuters into London, a number of large factories, and a growing service sector within the locality. There were good transport links to local areas (public transport, private car, and specialist transport) that facilitated a wide range of people attending social groups who lived in different geographical areas, such as, the city, the suburbs and nearby rural areas and villages.

The actual study sites chosen reflected different dimensions embodied within the notion of active ageing, namely the promotion of both an *active* mind and an *active* body<sup>19</sup> and included:

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<sup>19</sup> See appendix one: characteristics of study sites.



- (1) 2 yoga classes (1 group for people aged 50 years and over, 1 group for people living in sheltered housing): *active 'body'*
- (2) 1 'keep fit' class for people aged 50 years and over in the local sports centre: *active 'body'*
- (3) 2 computer classes for people aged 50 years and over: *active 'mind'*
- (4) Age Concern café: *neutral*

The rationale for these different study sites was in order to capture a range of perspectives and ideas about *active* ageing. All of these study sites were for people aged 50 years and over that reflected the target age for health promotion policies and the work of ageing organisations. Within social and political life the age of 50 years is conceptualised as a significant turning point within people's biographies: this age may therefore influence their social and personal identities.

### Negotiating access

In order to facilitate access to members of study sites I first liaised with the organisers of the groups. With permission from the group organisers and their members I attended each of the study sites. I spoke to the groups as a whole and with individual members. All potential participants were given an information leaflet about my study and asked to complete a request form if they were interested in participating in the research (see appendix two).

Members of these groups were predominately receptive to my research and willing to be involved. The main reasons that people gave for participating included an interest in the topic, altruistic motives in terms of assisting a doctoral student, and / or the

opportunity to talk about their lives. I also received a number of refusals. The reasons for not wanting to be involved were being too busy; not feeling comfortable talking about their lives; or due to their perceptions of the topic: age was often cited in this context, for example, one woman said ‘is it about ageing, wrinkles, grey hair, oh no I don’t want to think about that’, and another woman said ‘I am too old for that sort of thing’. Whilst older people are often imagined as ‘vulnerable’, within the research context, refusals can also be seen as an example of the agency and power that older subjects exercise within the research process (Russell, 1999).

A process of informed consent was negotiated with all participants who agreed to be involved in the study. Negotiating informed consent involved establishing the rights and privacy for the participants and was an ethical imperative to establish mutual trust between researcher and participant (Homan, 1991; Kayser-Jones and Koenig, 1994; Gilhooly, 2002; Mauthner *et al.*, 2002). Mutual trust is vital in order to develop rapport during an interview in which a researcher gains personal, and at times intimate, information (Kenyon, 1996). Before the interview the purpose and aims of the research were fully explained and written information provided (see appendix two). Participants were given opportunities to ask questions about the research. There was at least 24 hours between agreeing to participate and the actual interviews as recommended by the British Society of Gerontology (BSG, 2007) ethical guidelines. The willingness and informed consent of the participants was therefore made certain.



The sample<sup>20</sup>

Interviews were completed with 50 participants aged between 50 and 96 years (see tables one, two and three). There were differences in chronological age related to gender; women represented a wider range of ages from 50 to 96 years, and the ages of the men were between 52 and 80 years. This may relate to gendered differences in chronological age in later life (Victor, 1991, 2005) or due to influences of the sampling strategy. Within the sample there were a range of current and former marital statuses that included: 26 married, 6 divorced, 14 widow/ers and 4 single (never married). One black Jamaican woman was interviewed; all the remaining participants were white. The participants predominately lived in one or two person households that reflected the trend of older people in the white population to either live alone or in coupled partnerships (Phillipson *et al.*, 1998; Phillipson, 1998). The black Jamaican woman lived with her granddaughter and a small number of the participants in their early fifties had adult children living at home.

<i>Age</i>	<i>Male</i>	<i>Female</i>	<i><b>Total</b></i>
50-59	5	6	<b>11</b>
60- 74	10	18	<b>28</b>
75 +	3	8	<b>11</b>
<b>Total</b>	<b>18</b>	<b>32</b>	<b>50</b>

**Table One:** *Summary of gender and chronological age amongst sample*

<i>Social Class</i>	<i>Male</i>	<i>Female</i>	<i><b>Total</b></i>
Working	5	15	<b>20</b>
Middle	13	17	<b>30</b>
<b>Total</b>	<b>18</b>	<b>32</b>	<b>50</b>

**Table Two:** *Summary of gender and social class amongst sample*

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<sup>20</sup> See appendix one for summary of sample characteristics

Ethnicity	1 black Jamaican (woman) 49 White
Marital status	26 Married: (15 women (1 with new partner); 11 men) 6 divorced (2 women (1 with partner), 4 men (3 with partner)) 14 widow/ers (12 women; 2 men (both with partners)) 4 Single (never married) (2 women, 2 men (1 with partner))
Accommodation	7 participants lived in sheltered housing (1 of these was also housing association) 5 lived in housing association/council properties 38 were home owners (1 owned their council flat) 1 lived in rented accommodation
Employment status	35 retired 5 participants received income support (3 men, 2 women) 8 were in paid employment 2 full time carers (both women, for their husbands)

**Table Three:** *Summary of other key characteristics amongst sample*

Diversity was reflected in the sample in relation to: (a) current employment status: with 35 participants retired, 8 in paid employment, 2 were full time carers and 5 received income support; and (b) type of accommodation: with 38 home owners, 5 people living in housing association / council properties, 1 person living in rented accommodation and 7 participants living in sheltered housing (1 of these was also a housing association scheme). All of the participants lived independently with no-one receiving formalised support from community health and social care services.

There were social class differences with 20 participants described as working class and 30 as middle class. There were difficulties in designating a class position due to generational and biographical changes throughout the lifecourse (Vincent, 2003; Victor, 2005; Walker and Foster, 2006). This was especially evident from the biographical data elicited in the context of the in-depth interviews. For example, one



woman described herself as a child amongst eight siblings who lived in council accommodation, her parents occupations included being a cleaner and builder; on retirement she was in a senior position within the civil office and lived in a five bedroom house. Other participants had changed their occupations due to ill health or following retirement that did not reflect their main occupation. Women had often had many different caring and paid employment roles during their lifetime. Due to these complexities the following criteria were used to describe differences in social class: main occupation (within biography or key occupation of main partner); home ownership; benefit entitlements; and highest educational attainments. This level of analysis was sufficient as the key rationale for sampling for social class was to enable me to analyse the influences of different resources, in particular financial resources, on different lifestyles, meanings and experiences of everyday life.

Limitations to accessing people via membership in groups are that this approach may be biased against older people who are more isolated (Williams, 1990) or experience higher levels of disability or dependency. Despite these initial concerns, a number of participants within my study said that the aim of attending the café or the group classes was to reduce their feelings of social isolation. This was especially the case for recent widow/ers and full time carers. Also the status of health and dependency levels of the participants was varied. For example, one participant said that in all likelihood she only had a few months to live due to her COAD (chronic obstructive airways disease). Her reason for attending the computer class was to learn how to use the e-mail so she could keep in contact with her family who lived overseas. People can be attending different social groups and settings for many reasons.

At the same time negotiating access via group membership, embedded within the everyday worlds of people aged 50 years and over, provided some important insights into the nature of gender and social networks in later life. The invisibility of older men is frequently referred to both in relation to the limited coverage of their everyday lives and the gender blind nature of research (Thompson, 1994; Davidson *et al*, 2003 a, b). It is argued that older women are more likely to participate in research than older men. Davidson *et al* (2003a, b) relates difficulties accessing older men to their distinctive social networks, either in relation to their former or current marital status, in which women are seen to take the prime role in creating and maintaining social networks, or in terms of their work-life and social activities, with friendships predominately built either at work or in particular social settings, such as, ‘competitive’ sports arenas and / or social clubs (Davidson *et al*, 2003a).

One third of my sample included men, two thirds were women (see tables four and five). After reading my fieldnotes I identified a number of possible reasons for this. First, certain areas of social life were clearly gendered. Both the yoga classes comprised women. Moreover, the majority of the residents in the sheltered housing scheme, of a higher chronological age, were women. Second, accessing people via 50+ groups may have influenced the sample as members of these groups must identify with this aspect of their age identity. For example, it could be argued that attendance at these groups may compromise the sense of masculinity for some men in relation to traits, such as, competitiveness, dominance and independence (Meadows and Davidson, 2006). It was interesting to note that the men attending the 50+ sports



club were either with their partner or had been advised to go by their medical practitioner due to concerns about their body weight and / or health. The motivation for attending the sports centre was not therefore primarily motivated by the traditional masculine image of the competitive nature of sport (Davidson *at al*, 2003a).

<i>Study site</i>	<i>Men</i>	<i>Women</i>
Yoga (7)	0	7
Yoga chair (5)	0	5
Keep Fit / sports centre (11)	5 (1 snowball = neutral)	6
Café (14)	4	10 (1 snowball)
Computing (13)	9 (1 snowball = neutral)	4 (1 snowball = neutral)
<b>Total (50)</b>	<b>18</b>	<b>32</b>

**Table Four:** *Characteristics of gender amongst the sample in relation to different study sites*

<i>Sampling criteria</i>	<i>Men</i>	<i>Women</i>
Active Body (22)	4	18
Active Mind (11)	8	3
Neutral (17)	6	11
<b>Total (50)</b>	<b>18</b>	<b>32</b>

**Table Five:** *Summary of sampling criteria in relation to gender*

The men at the computer classes were often volunteers, and had positions of authority and power in their role as experts and teachers, and computing is an interest that resonates with the portrayal of technology as a male (and disembodied) pursuit. In contrast, at the café solitary men and women, groups and couples all attended thereby representing a more open and shared gendered space. These were significant insights about the gendering of social space in later life. All of these access routes were also subsidised either by voluntary organisations or the council, the exercise classes were

not expensive, the café provided an affordable meal and the computer classes were free. This was probably significant in capturing diversity in terms of financial resources.

### Developing a visual methodology

Visual images are ‘everywhere’ (Pink, 2001) so that it was necessary to select images that not only reflected a diverse and sensitive approach but also elicited important insights into older people’s social worlds. The development of a visual methodology therefore needed to be explicit (Rose, 2001) and appropriate and ethical to the research context (Pink, 2001). To achieve these objectives my selection process involved the following stages<sup>21</sup>:

- (1) Identifying images that reflected key themes in the literature, for example, active / passive, freedom / dependency, mind / body;
- (2) Involving older people as active participants in the selection process; and
- (3) Piloting interviews to evaluate the effectiveness of different visual images.

The first part of this process involved an exploration of visual images associated with ageing, well-being and health. My focus was on ‘mundane’ and everyday images (Bytheway and Johnson, 1998) available within the localities of the study sites: visual images that are continually developing and changing over time. I collected visual images over a period of 3 months both in the localities of my study areas and at the national level. The search and analysis was therefore a ‘snapshot’ of a moment in a particular time and space. This included searching for images in magazines, community centres, local libraries, health centres, local ageing organisations, national

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<sup>21</sup> See Martin (2004) for a full description.



ageing organisations, and from government sources, such as, the Department of Health. This generated over 300 sources of images that were targeted at people aged 50 years and over. From this initial search I identified 2 prevailing themes:

- (i) *Active Ageing*: this included images of being active through physical activity, such as exercise (e.g. swimming, cycling, jogging, walking), group activities, the promotion of paid and unpaid (voluntary) work and images of learning opportunities in later life, such as computing.
- (ii) *Health, Risk and Dependency*: this included visual images of health risks, everyday risks associated with safety and security, and images of embodied dependencies, such as, the use of mobility aids and caring relationships.

These themes resonated with the two alternative images evident in active ageing (see chapter one) and were focused on ageing bodies. Gender, ageing and the body were further intertwined within these visual images, with men more likely to be portrayed as active and the women as dependent and passive. This analysis therefore highlighted a further dilemma about how to reflect the heterogeneous and diverse nature of later life, for example, for whilst visual images of old age are notably gendered (see Furman, 1997; Fairhurst, 1998), it was important to ensure that the images resonated with the lives of both older men and women.

The next stage of the selection process directly involved older people as active participants. First, I discussed a sub-sample of the visual images with 2 older men and

2 older women <sup>22</sup>, and second, I piloted the use of photo-elicitation during 4 preliminary interviews. The reasons visual images were finally selected were following an analysis of the responses from these consultations. Some images appeared to elicit important insights into the participant's social identities. For example, an image of an 'active' couple (see appendix three, visual image one) elicited responses about the 'positive' and 'happy' nature of the image. For other participants the image was experienced in terms of loss, for example, following the experience of divorce, widowhood and / or as a full time carer for a partner. Some images did not appear to resonate at all with the participant's social worlds, with all of the responses to a middle aged man saying 'I don't have anything to say about that'. Similar responses were also elicited in relation to a number of similar images. Following this selection process 12 visual images were identified as appropriate to use in the photo-elicitation method. These images are set out in appendix three in the order they were presented and viewed during the interviews <sup>23</sup>.

This process highlighted a further dilemma: the involvement of people with visual impairments may find this method difficult. This concern was highlighted later in the

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<sup>22</sup> From the initial search I identified and extracted 15 sources from each of the key themes to illustrate different aspects of health, well-being and ageing.

<sup>23</sup> I would like to emphasise that ethnicity was also an important dimension within the analysis and selection of the visual images. There were a number of themes that emerged in the context of ethnicity. First, more images representing diversity in relation to ethnicity were evident in the last few years. Second, there were more images of different ethnic groups within the theme 'health, risk and dependency'. Third, when piloting the visual images cultural factors and skin colour were identified as significant within the images before any associations with ageing. As Rose (2001) argues visual images are both a reflection of social context and have their own effects through the production and reproduction of social difference. At this stage I decided that including ethnicity as a variable within my research and sampling would be complex and difficult in relation to my time and resources. I would not be able to consider ethnicity with the depth and cultural sensitivity of analysis required. I therefore acknowledge that my research study does not reflect the total diversity of later life, but focuses on some key variables reflecting aspects of the heterogeneous nature of ageing.



project when one of the participants who took part in my study was blind. However, his involvement questioned our taken for granted nature and meanings of the visual in everyday life. Important insights into the (non)-visual aspects of his life were highlighted, as other senses, such as sound and touch, were heightened and how he related moments in his inner world to his visual memories of Munch's *'The Scream'*. He also had memories of older people's bodies, such as grey hair and wrinkles, features he could no longer see in the immediate 'other' or self. Visual memories did however continue to have important significance, resonance and meanings within his everyday life.

### The interviews

The interviews involved 50 participants: 42 participants were interviewed alone and 8 as couples <sup>24</sup>. The participants were asked to choose the venue and interviews took place in a variety of settings that included the participant's own homes, the café, a private office in a voluntary organisation, at the sports centre and in a 'private' area of a foyer at the computing centre. The interviews lasted between one and two hours. Fieldnotes were taken after every interview. With permission all the interviews were tape recorded and fully transcribed. The interviews involved the interconnection of two data collection methods: in-depth semi-structured interviewing and photo-elicitation.

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<sup>24</sup> The participants chose to be interviewed as couples. This included two long term married couples and two newly formed couples. This reflected a significant emergent theme in the research – perceptions and experiences of coupledness in later life. The married couples seemed to 'take for granted' that I would want to speak to them both at the same time. The newly formed couples asked if I would interview them together.

The interview schedule was similar for all participants (see appendix four). The interview first involved biographical information that was introduced by asking the participants what had been important in their lives. The focus of this part of the interview was to explore 'stories, accounts and narratives which describe turning-point moments in individuals' lives' (Denzin, 1989b, see Birren *et al.*, 1996; Bornat, 2002). The interview then focused on their current and immediate lives, in particular, an exploration of their daily lives. To explore their everyday worlds the participants were asked to describe a typical day, such as, 'what did you do yesterday?'. This method was based on an interviewing technique described by Calnan and Williams (1991) to explore ideas about health in daily life. These aspects of the interview were open ended to allow participants to discuss topics, experiences and meanings that were important to them. Later in the interview topics related to health, lifestyles, ageing and health promotion were introduced. Finally towards the end of the interview each participant was shown 12 visual images and asked: 'how do you relate to this image?', 'what are your thoughts on this image'. The visual images were therefore a form of vignette to enable comparison between interviews (Finch, 1987; Bendelow, 1993, 2000). In this way the interview could be described as focused; the purpose of the interview guide was therefore to ensure all main topics were covered (May, 1993; Kaufman, 1994; Grbich, 1999).

I gave particular attention to the interactional and social context of the interviews. Feminist researchers have questioned their own roles and power relationships within the interviewing process (Oakley, 1990; Oakley and Callaway, 1992; Finch, 1993; Ribbens and Edwards, 1998; Mauthner *et al.*, 2002; Miller and Bell, 2002). Oakley



(1990) has, for example, argued that a formal structured approach creates a hierarchical relationship between interviewer and interviewee that risks objectifying women. Underlying these debates is a tension between subjectivity (a reflective awareness of the social context to promote flow in the conversation) and objectivity (the elicitation of knowledge free of bias) within the interview (May, 1993). Whilst intersubjectivity promotes full engagement within the research relationship, the pursuit of objectivity requires varying levels of detachment and distance. These concerns highlight the significance of emotion work and feeling rules (Hochschild, 1979) within the interview context (Kleinman and Copp, 1993; Young and Lee, 1996): emotions experienced by both the interviewer and participant.

My approach to the interviews was based on feminist principles that promote non-hierarchical relationships and encourage the development of rapport and trust within the interview (Oakley, 1990; Finch, 1993). The approach to the interviews was 'active', a view that advances the idea that an interview is a collaborative and meaning making enterprise (Holstein and Gubrium, 1995; 2002). As Holstein and Gubrium argue:

*Construed as active, the subject behind the respondent not only holds facts and details of experience, but, in the very process of offering them up for response, constructively adds to, takes away from, and transforms the facts and details. The respondent can hardly "spoil" what he or she is, in effect, subjectively creating*

(Holstein and Gubrium, 2002, p. 70)

The interviews therefore approximated a 'natural' conversation in which I explored beyond the surfaces to engage with 'implicit questions, alternative frames and the content of categories created and used by the informant' (Sankar, and Gubrium, 1994, p. xiii). Meaning was therefore co-constructed between me and the participants.

Differences in experiences of interviewing men (Lee, 1997; Schwalbe and Wolkomir, 2002) and women (Oakley, 1990; Reinharz and Chase, 2003) have been documented. The issues explored often relate to different dimensions of power and control within the interview and the willingness to talk. Emotional aspects of interviews are also relevant (Kleinman and Copp, 1993; Carter and Delamont, 1996; Young and Lee, 1996). In my research I interviewed most of the men in 'public' areas, such as, the café and computing class foyer, and most of the women in their own homes. I found both men and women willing to share their ideas and lives with me; emotions were expressed by some women and some men. The men interviewed as part of newly formed couples felt willing to share their emotional experiences of their divorce / bereavement; and this appeared to be a dimension of the 'reflexive' process of sharing information within intimate relationships, and the presence of their partner may have facilitated this openness (Giddens, 1992; Riggs and Turner, 1997; Jamieson, 1999). The 'ideal' of non-hierarchical relationships did however feel easier to achieve with women than men. For example, one man I interviewed, who had previously been in a high ranking position within a large organisation, appeared to 'dictate' his views to me: it was me that felt like the 'passive vessel' in this situation.



Perceptions of my 'chronological age' further influenced the interviews with my embodied age often used as a reference point, for example, when referring to daughters / sons within my generation and / or to emphasise age identity and difference, such as, the comment: 'well now you know what it is like to be over 50'. The interplay of gender and age therefore influenced the interview setting and further highlighted the social context of interviews (de Laine, 2000) as gendered and embodied situations.

### Ethical considerations

The research study was conducted within an ethical framework recommended by British Sociological Association (2002) and the British Society of Gerontology (2007). Attention was given to the ethical principles of informed consent, confidentiality and privacy. A process of informed consent was undertaken with all participants. To ensure confidentiality and privacy of the participants, all names and identifying information were changed immediately following the interviews. Transcripts and tapes were anonymised and kept in a locked cabinet. Participants are not identified in this thesis or any concurrent and subsequent papers. As Sankar and Gubrium argue, informed consent 'creates a continuous ethical obligation ... that the privileged access will not be used to the participant's detriment' (1994, p. xiv). This ethical obligation was ongoing throughout the whole research process, from design to fieldwork to writing up, when personal and private issues of people's lives are translated into the public domain. These ethical considerations have been central to the management of this research.

The interviews were conducted in a sensitive and supportive way and any signs of potential distress monitored (Gilhooly, 2002). This was especially important to enable participants to voice their own concerns, ideas and meanings. As visual images have rarely been used in interviews with older people, special attention was given to the use of the photo-elicitation method. A responsive approach was required to ensure that the participants were not shown visual images that they may find upsetting. The predominant feeling amongst the participants was that viewing the images was interesting and enjoyable; however, for others an occasional image evoked difficult memories and sad feelings. I needed to be aware that every participant had a different and complex biography that influenced their viewing of the images.

#### Data analysis.

The interpretation of the data within this research study was not a distinct phase but emerged throughout the whole research process from fieldwork to writing up (Okely, 1994; Coffey and Atkinson, 1996). There was a continual interplay between data collection and analysis as I moved between reflecting on my fieldwork notes, the transcripts and my analytic notes / memos (Strauss and Corbin, 1994). I therefore immersed myself in the data to identify different elements of meaning in order to generate codes, categories and themes. A reflexive process to the analysis was therefore taken to ensure methodological rigour and creativity (Coffey and Atkinson, 1996). The emergent themes were continually guided by the research questions.



The data was thematically analysed using Atlas Ti <sup>25</sup>. The process of coding involved the following stages (Strauss, 1987; Fielding, 1993b; Coffey and Atkinson, 1996):

- Open coding as units of meanings (phrases, sentences, paragraphs etc.) were labelled i.e. data separated into segments.
- Axial coding as open codes were built up into categories i.e. a process of teasing out and expanding the data in order to formulate new questions and levels of interpretation
- Selective coding as categories were joined together to generate concepts and themes
- Thematic coding across all the transcripts and an exploration and development of relationships within and between the themes (for example, in relation to gender, social class and chronological age)

The process of coding was therefore a ‘mixture of data reduction and data complication’ (Coffey and Atkinson, 1996, p. 30), that is, a process of fracturing the data in order to generate higher levels of abstraction and interpretation (Strauss, 1987). As well as separating the data into coded segments I also examined the transcripts as a whole to examine the significance of the participant’s biography on the data. Through analytical engagement with the data any preconceptions of mine were questioned and new ways to look at the data continually found. As Strauss and Corbin argue the process of coding ‘forces the researcher’s own voice to be questioning, questioned and provisional’ (1994, p. 280). The final stages involved the ultimate integration of the whole analysis by interpreting and making sense of my

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<sup>25</sup> This involved 2 and a half days training at CAQDAS (Computer Assisted Qualitative Data Analysis) project, University of Surrey. See Atlas.ti Introductory Workshop: Handout.

data in relation to the wider theoretical perspectives (discussed in chapter 1) and making decisions about how to present the data in written form that are presented thematically in the following chapters (3, 4, and 5).

### Validity and Reliability

The integrity of this research lies in the quality and rigour of the research process. It is through analytical rigour and multiple ways of engaging with the data that claims of validity can be made (Silverman, 1993, 1998; Coffey and Atkinson, 1996; Seale, 1999). The validity of the research also relates to the rapport I developed with the participants and my continual questioning and reflexive approach. Whilst this research study claims high levels of validity it does not claim to be representative of the views of older people as a whole, and in that context is not replicable, but the study has nonetheless generated important insights into the localised and everyday social worlds of the participants.

### Concluding comments

The design and conduct of this project has been to elicit insights into the lived experiences of everyday life of a diverse group of people in mid to later life in *their own terms*. In particular, the research has linked visual images of ageing with the lived experiences of older people. In the following chapters I thematically present the data that emerged from the in-depth interviews and photo-elicitation methods. Chapter 3 explores the lived *experiences* of and the ‘*doing*’ of age, ageing and the body in context of the participant’s everyday lives. Chapter 4 highlights the significance of gender, emotions and ageing in the context of everyday life. Chapter



5 focuses on the meanings, perspectives and concerns that participants expressed about their health, health-related lifestyles and perceptions of 'risk'. Within this process the data elicited from the in-depth interviews interweaves with the data from the photo-elicitation methods. In representing the participants from this study I have made an effort to promote their subjectivity and allow their own voices to be heard as much as possible. In this context I use the term participant, not subjects, to attempt to question and challenge the objectification of both older people and the asymmetry of the traditional researcher / subject relationship (cf. Furman, 1997).

### 3

## Ageing, the Lived Body and Everyday Life

*As you become older you do become aware of more things, you know, you become aware of your health, your body, your brains, how you look ... Oh either you feel that your brain is going you know. I just can't remember things. How you look. How your skin is ageing. How you get lines like those which you would love to get rid of. And you sort of think to yourself I don't like old age you know.*

*You can't rush anywhere, you can't do the things you used to do that you used to take for granted. When you are young you take them for granted*

(Gill, aged 70 years, working class)

This quotation by Gill resonated with many themes that participants articulated in relation to their embodied participation in everyday life. First, Gill expressed a heightened awareness of her health, her body, her brains and her appearance. The taken for granted 'absent' body has become visible within Gill's everyday world. Second, within Gill's discourse was a distinction between her (outer) *body*, associated with her ageing skin, and her *mind*, associated with her 'brain' and memory. Third, Gill says she was 'doing' less. For Gill, these bodily changes were connected to the



social identity of 'old'. Gill's lived experience and praxis of growing older was clearly embodied.

The focus of this chapter is to further explore the lived experiences of embodiment as articulated by the participants within the context of their everyday lives. This will include an exploration about 'how people *themselves* interpret and discern what it is like to grow old and be older in today's world' (Gubrium and Holstein, 2000, p.3). It has been through an exploration of the mundanity of everyday life, the ordinariness of daily living, that I have engaged with the perspectives, concerns and meanings of people in later life about their own experiences of and the 'doing' of their lived bodies in everyday life. In particular, this chapter will explore how the participants talked about the experience and praxis of their lived bodies, and the personal and social meanings associated with their embodied participation within their social worlds.

The data presented in this chapter emerged in the context of both the biographical interviews as participants described and talked about their experiences of daily life and as part of the photo-elicitation techniques towards the end of the interview. Whilst every participant was asked specific questions about age and ageing it is important to note that many of these themes emerged spontaneously throughout the interview unprompted by me as the interviewer. This suggests that age, ageing and the body have significant meanings within the everyday discourses of the participants.

## **Experiencing Ageing, the Body and Everyday Life**

Many participants experienced their bodies as a taken for granted aspect of their everyday lives until moments and / or times when an awareness of the body interrupted their daily activities. This was especially evident when participants experienced changes to the lived body, for example, ill-health, aches and pains, bodily limitations, diminished energy levels and / or signifiers of ageing, such as wrinkles, increased body weight and / or greying hair. Alternatively bodily transformations were reflected back to the participants via visual and discursive images, from corresponding physical changes amongst family and friends and / or from glimpses of their own bodies in mirrors. It was at these moments when the everyday visibility of the body was heightened that participants reflected on their own meanings and identities associated with age and ageing.

Experiences of the lived body were central to the participant's discourses about age and ageing. This was especially evident when participants experienced bodily changes that were associated with a heightened awareness of ageing. For example, many of the participants described the 'aches and pains' that developed with increasing chronological age:

*I don't mind getting older. It is the aches and pains that come with it you can do without.*

(Peter, aged 66 years, middle class)

*Your body grows older, that's where you get all the aches and pains, things like, just normal consequences of getting old, just creaky and wonky, your*



*joints, your muscles things like that, don't move as smooth as when you were younger.*

(Julian, aged 55 years, working class)

The physical performance of the body was significant to the participant's perceptions of age and ageing, in particular, the functionality of the joints, muscles, aches and pains, chronic illnesses and bodily limitations. Frequently mechanistic metaphors lay beneath these embodied discourses in terms of how the body was seen to be working or not in terms of its optimum functioning. For example, Pauline referred to the body in terms of its physical functioning:

*Pauline: 61 - It means I am getting older. It means the body is not working, in parts it doesn't work, as it should of course.*

*Int: What do you mean by that?*

*Pauline: Oh little things. I think once you get to 60, you notice things aren't quite the same as they were before. It may be trivial things like the thinning of hair. I have an underactive thyroid that doesn't help. Otherwise I think I am pretty good. I could lose a lot of weight which would help.*

(Pauline, aged 61 years, working class)

Pauline described perceived changes to her body, a chronic illness, increased body weight and loss of hair, in terms of a mechanistic metaphor of the body as a machine. When the body was viewed in terms of its workability, its functionality as a machine, there was an underlying sense of the inevitability of ageing experienced as a process of biological decline:

*You are bound to have things wearing out. You are not wearing the same clothes as you were born in. So how do you expect the body to be the same?*

(Rachel, aged 77 years, middle class)

*It is just the realisation that age is creeping up on you and the system begins to break down in odd places. Like any other mechanical object after a while they need a bit more TLC. You can't drive them quite so hard, quite so fast as when they were new. And I think your body is similar. Things start to break down*

(Simon, aged 58 years, middle class)

The inevitability of biological decline was associated with a heightened awareness of ageing. Both men and women participants described the functionality of their bodies but there were differences in how the body was described. Different metaphors were used, men for example used more mechanistic terms, such as cars and machines, and more frequently referred to the functioning of parts of the body, such as muscles. In contrast, women's discourses interconnected subjective feelings about the functionality and appearance of the body: the functionality and the subjectivity of the ageing body were inextricably linked. An ageing lived body that wasn't working effectively as before was frequently described in relation to the following adjectives: 'creaky', 'crippled', 'stiff' and 'crumbling', such as:

*Bits of me are crumbling. It is just wear and tear.*

(Barbara, aged 66 years, middle class)

In this context, the discourses drawn upon to describe the ageing body emphasized a sense of inevitable decline following a long period of wear and tear. This process of inevitable and bodily change was further experienced as a gradual process:



*I think it is all gradual, you know, and I think the reason is because nothing has happened to me yet, you know. Touch wood. Any health thing, you know, would affect me. But I suppose nothing has been noticeable*

(Patrick, aged 64 years, middle class)

Underlying this gradual and slow process, in which one's own bodily transformations are not so evident, was a sense that age 'creeps' up on you. This process of gradual bodily changes further emphasised how the lived body was experienced as an absence / presence, in/visible entity within the lived worlds of the participants. For example, Gary reflected on his own bodily experience of ageing when looking at the visual image of the hands <sup>26</sup>:

*I think I quite often look at my hands and think they are getting older. I mean, I do sort of have moments, when I look at some of these things very old in appearance. I do have moments when I feel old. I guess all of us are constantly to some extent changing our appearances and so it is a gradual process, so I think in terms of yourself, you just get used to those changes, because they have happened slowly*

(Gary, aged 54 years, middle class)

The in/visibility of ageing was therefore experienced as a slow and gradual process that was only consciously reflected upon in relation to certain (and often visual) prompts.

When asked about the meanings associated with their own current chronological age, it was frequently the experience of the lived body that was described:

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<sup>26</sup> See visual image nine (appendix three).

Theresa: *Well I don't feel very different now I am 68. I don't really feel any different than I did when I was 58. My perception isn't that I am nearly 70, and yet my body tells me I am not as active as I was.*

Int: *In what sort of ways?*

Theresa: *Well I am a bit stiffer, I am a bit stiffer. I am not so nimble. I don't sleep terribly well. I didn't sleep terribly well when I was 58, but that was because I was worrying about the job. I have sleepless nights. I do not know what is around the corner for me.*

(Theresa, aged 68 years, middle class)

Whilst Theresa's own subjective feelings about her sense of self have not changed, her own experiences and perceptions of her lived body in everyday life, such as being stiffer, less agile and having sleepless nights, were discussed in the context of a heightened sense of age and ageing, with an awareness of an increased sense of bodily vulnerability suggested, when she says: '*I do not know what is around the corner for me*'. Some participants pointed to specific bodily signifiers, such as hair colour, body weight, and wrinkled skin that led to a questioning of their own age identity. For example, the following participants described changes to their feet in the context of ageing:

*I mean you die on your feet as you get older. You find you can't squeeze into shoes you used to wear. That comes as a big shock.*

(Gill, aged 70 years, working class)

*And I can't reach my feet so that means that I struggle with that. But I know I will get there eventually but I do have to struggle to do it. That is, and part and parcel of it, everybody around here will tell you the same, the feet*



*disappear from the body, they just don't want to know you, apart from walking on.*

(Stella, aged 73 years, working class)

When looking at the visual image of the hands <sup>27</sup> Catharine pointed to and described her own arms:

*Hands. Yes. They are old aren't they. Old and wrinkled. That is the way that you can tell that I am old under here, all wobbly and wrinkly.*

(Catharine, aged 83 years, middle class)

There are certain bodily signifiers, such as, the hands, feet and neck, that were viewed as key indicators of old age that could not be changed. Many participants questioned to what extent the inevitable process of age and ageing could be changed and to what extent the body was elastic:

*Yes that is it the hands isn't it, they give away. Mine are bad but they are not - some of these things you know you can rub cream on but you can't beat age - age comes up on you and you have got to accept it.*

(Mair, aged 84 years, working class)

The inelasticity of parts of the body was more frequently described by women. However, this may also be related to chronological age, as more of the women were older: experiences of deep old age were different. Awareness of bodily changes therefore led to a questioning of identity in relation to age and ageing, in particular, comparisons were made to the experience of different and predominately younger chronological ages:

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<sup>27</sup> See visual image nine (appendix three).

*There isn't an age I would be happier. I am quite content with now. I think I have always been quite content with now. So it is not as though, oh I wish I was 36. I don't feel that at all. But there are some things about ageing I don't like. Which I would rather not have ... My vision is failing. I wear contact lenses. I wear bifocal contact lenses but even so reading is difficult and reading in bad light is difficult. So – and that is entirely down to my age. And I would rather not have that. My hair is largely grey and you know it would be nice, actually it wouldn't be nice not to be grey, because it would look daft with my skin tone but even so things like that. Even though I consider myself fit and healthy, if I sit too long or when I get up I feel stiff. And I stretch and I think I don't remember feeling stiff when I was younger. So those are the things I would prefer to be without*

(Sylvie, aged 52 years, middle class)

As a yoga teacher Sylvie was content with her embodied age but changes to her body, her vision, grey hair and stiffness, have heightened her sense of growing older. Whilst the body was taken for granted when young, the lived body now frequently intruded into her everyday experiences of life. At these moments participants, like Sylvie, became aware of their own body and the ways the body had changed. The ageing body in everyday life was therefore not experienced as a constant presence nor an absent entity but as an in/visible transient and fluctuating absence / presence within their everyday lives (cf. Gubrium and Holstein, 2003a).

The transience of the lived experience of the body can further be illustrated with the distinction between 'good' and 'bad' days depending on how intrusive the body



was within the participant's daily schedules. For example, Ken described his walk to work:

*Ken: Well we all have good days and bad days. And I am no different. I don't have many of them but occasionally my hips will be particularly bad and even walking from the car to the office or up the stairs can be a struggle. And those situations usually last all of the day. And during those days I know I am restricted. And that annoys me .. There are days when I just feel feeling generally blast off I don't know why. I don't have many of them.*

*Int: Blast off?*

*Ken: Because maybe it is a day when my body is telling me you are getting older. And I suddenly realise it. It is happening more frequently nowadays when I realise I am no longer 30, 40, 50.*

(Ken, aged 64 years, middle class)

For Ken, awareness of his body predominately intruded on what he described as his 'bad' days. On these days his hips were painful that constrained his mobility. The taken for granted body that he experienced on the daily and habitual walk to the office was clearly noticeable; the lived body of everyday life intruded into his daily routines. Ken directly related these bodily limitations, and his increasing sensations of pain, to his chronological age. In particular, he compared his current bodily experiences to his experiences of a more youthful body at differing chronological ages: the everyday experiences of his lived body heightened his awareness of growing older.

Participants also experienced a heightened sense of age and ageing when bodily transformations were mirrored in visual images, in corresponding bodily changes of friends and families and / or when seeing glimpses of their own bodies reflected back in mirror images. This increased awareness of growing older was often associated with a corresponding disparity between an enduring (inner) younger self within an ageing (outer) body:

*That is when you start thinking, God, I must be old. I looked in the mirror when I was out with Sam (his grandson), and I thought, who is that old guy behind Sam? and, of course, it was me .. (laughs) .. But inside you don't feel the age you are. I still think like a 20, 30 year old. Well I think I do. But it is not until I look at things like (looks at his own hands), that, the skin and everything else, yes.*

(Peter, aged 66 years, middle class)

This quotation resonates with the idea of the ageing body as a 'mask' that disguises a more youthful inner subjective self (cf. Featherstone and Hepworth, 1990, 1995a, 1998). Peter identified with growing older, in relation to visible bodily signifiers, such as wrinkles and grey hair, bodily reminders that have been reflected back to him from a glimpse of his (outer) body in a mirror image. This visible image contrasted with an (inner) sense of self that felt much younger than the sight of his own ageing body. The contrast between these two images of ageing, an (outer) mirror image of his (whole) ageing body and an experiential (inner) more youthful embodied self, connected to ambiguities in his own sense of embodied age and ageing as Peter fluctuated between a younger sense of self and the appearance of his body associated with ageing features, such as, sagging skin. This was reflected in frequent



descriptions between inside and outside of the body as participants tried to make sense of their embodied self and perceptions about how their outer bodies were viewed. This sense of disparity between the inside / outside can be reflected upon due to certain experiences within everyday life. Hannah, for example, described a conversation during a visit to a shop following which she questioned her own embodied self image:

*Your own self image doesn't actually change much until something comes in to disrupt your heart .. I went into a shop to buy towels and the shop assistant said to me are you over 60 because there is an extra discount for people over 60, I haven't got there yet, so something like that will disrupt your self image for a while, but inside, I think you are probably still what you were*

(Hannah, aged 58 years, middle class)

During the visit to the shop Hannah's actual chronological age was challenged by a question 'are you over 60' from the shop assistant, a question that 'disrupted' Hannah's sense of (inner) self. Whilst carrying out her daily activities, the everyday visibility of her ageing body, as viewed by other social actors, was unexpectedly heightened. The disparity between her sense of self, her chronological age, and her bodily appearance as seen by others led to her questioning her own sense of age and identity. Hannah's awareness of her embodied participation in her social world was intensified in the context of her social interactions.

Sarah further expressed an apparent distinction between her body and mind, when describing her brain and body that have different chronological ages:

*Sarah: 55. My brain isn't, the rest of me is.*

Int: *What age is your brain?*

Sarah: *My brain is still probably 25.*

Int: *What do you mean by that?*

Sarah: *Although I know your brain does age physically, I think in your mind, I don't think you do age physically in the mind, if you understand what I mean.*

*I know your body goes, you can't do anything about that, you can look after it but you can't stop certain age processes*

(Sarah, aged 55 years, working class)

Sarah's quotation suggests that there are limits to the perceived elasticity of the body, so whilst you can take care of the mind, ageing and decline of the body is inevitable. Sarah also alternately conflated the 'brain' with the 'mind' and distinguished between these two entities: whilst the 'brain' was seen as a physical entity that aged like the rest of the body, 'mind' in contrast stayed chronologically younger. This distinction within the lived body was articulated as a difference between a sense of an inner self, experienced as more youthful and enduring, and a corporeal body that grew older. Sarah further suggested that a younger (inner) self was expressed in terms of attitude, behaviour and the importance of keeping abreast of contemporary changes, such as, music, education and fashion. The significance of attitude and beliefs were central, for whilst participants identified with the identity 'old', it was important not to think and act like an 'old' person in order to promote a sense of well-being:

*I suppose some people have an older way of life, you know an older way of thinking about if you are, you are old, but you mustn't think you are old.*

(Fay, aged 80 years, middle class)



Other participants reflected on the bodily changes of others when seeing transformations in appearance and / or demeanour that showed their increasing chronological age:

*Well it may be change of hair colour, or it may be ageing facial features, I suppose, sort of slacker skin. Sometimes overall demeanor, sometimes when I see people who appear to be behaving like older people*

(Gary, aged 54 years, middle class)

The social identity 'old' was therefore not only about bodily appearance but also encompassed people's behaviour and attitudes, with some people being described as 'old' before their time:

*Some people behave like old people .. that is the old concept of the old granny sitting there in her rocking chair with the knitting needles and shawl around her shoulders*

(Simon, aged 58 years, middle class)

Imageries that were drawn upon included generational change with previous generations viewed as looking and acting 'old(er)'. Being denoted as 'old' therefore involved a complex interplay of visual bodily signifiers, age appropriate behaviour and a person's attitude and outlook to life; perceptions that were also contingent on generational and social factors. This was especially evident when participants reflected on their own memories of parents and grandparents:

*James: I must say I don't particularly fancy the ageing process bodywise. You know the ageing of the skin and the obvious things that come with it but on the other hand if you look at old people nowadays they don't age in that way do they. Do you think they do?*

Int: *In what way?*

James: *Well they don't get as old and wrinkly like my gran was and what have you.*

(James, aged 67 years, middle class)

Anna: *And I do think that old age, people are getting younger in their old age now. When my mother was 67 she was a little old lady sitting before me doing knitting, wasn't she, and my grandmother when she was 67 she was all sort of crumpled up like this type of thing. I don't want to be like that yet.*

(Anna, aged 67 years, middle class)

Images of 'old' were predominately gendered, with old wrinkled skin, white hair and a 'crumpled' declining body associated with older women, frequently grandmothers. Participants dissociated from these images of old age by a process of distancing old bodies as 'other'. This can be illustrated when Gill compared her sense of embodied participation in everyday life in relation to 'others':

*I mean I need glasses for reading obviously I get odd aches and pains but not like some people. You see some people and you think oh God how awful to be sort of housebound or in a wheelchair.*

(Gill, aged 70 years, working class)

The process of 'othering' the 'old' involved a process of separating the embodied self from the embodied discourses of 'old' associated with bodily limitations, nursing homes and being housebound.



Gary further explained how he recognised the visible bodily signifiers amongst others but he does not associate these with his own embodied self:

*Ageing is something that happens to other people. Because in other people, you can see the changes in other people, because you see their exteriors, and so if I haven't seen anybody for a while, I am always taken aback as to how much people have aged, but I don't see myself in those terms.*

(Gary, aged 54 years, middle class)

Social interactions are embodied, and when other social actors are viewed, it is their outer bodies that are seen and reacted to. As Gary says it is difficult to see your own body, the exterior of our bodies is predominately only seen as a form of reflection, both from mirror images, and increasingly in visual images associated with photographs and videos. As shown earlier, participants pointed and looked at parts of their bodies, such as their feet, wrinkled skin, or hands, which signified growing older. In our social interactions, however, as illustrated by Gary, it is the outer bodies of other social actors that are seen, bodies that reveal bodily changes associated with ageing, and are denoted as 'old': bodies that become a distant 'other' from our own sense of embodied self. Within the participants' discourses there was a contrast between their own bodies, experienced as a transient and fluctuating absence / presence within everyday life, and the observation of 'old' bodies of 'others' in social interactions and imageries. In this context, the 'othering' of old age, through the objectification of 'other' ageing bodies as 'old', reveals the process that enables old bodies to be seen as a constant objective presence in everyday life, a presence that is to be avoided and distanced. At the same time, the lived experience of one's own body can be transient, an unfinished biological entity that is continually reinscribed

and interpreted, within certain limits, through participation in everyday life (cf. Shilling, 1993).

The way older people resist the identity of being ‘old’ was evident within the participant’s discourses. Penny, for example, described how important her physical appearance was to her sense of age and identity:

*It is important in that I don’t particularly want to be seen as 63 next month.*

*So I still spend my money on clothes and I bother about the way I look. I never go out without makeup. I always have my hair done. I have a pedicure once a month that sort of thing. That matters to me.*

(Penny, aged 63 years, middle class)

Penny was concerned about her physical appearance and expressed the importance of always being ‘*clean and tidy*’. This involved engaging with a number of bodily techniques, a pedicure, colouring her hair and wearing make-up, that allowed her to perform and express her own idea of her embodied age within her everyday world. This involved a process of distancing from the social identity ‘old’: not wanting to look her age. Whilst both men and women viewed appearance as important, women were more likely to worry about their bodily appearance, that impacted on their sense of subjective well-being, and participate in age-resistant activities. The ability to engage with age-resistant activities was directly influenced by social class, as these activities required significant financial resources. Participants with limited resources recognised the constraints on their ability to change their bodily experiences of growing older, associated with discourses about accepting their age:

*Apart from that, once you have got over that problem, once you have thought*



*to yourself, well everyone gets old so we are all going to be in the same boat  
one day, you just get on with it and make the best of it*

(Gill, aged 70 years, working class)

The significance of bodily appearance, and the use of aesthetic age-resistant activities, was therefore related to gender and social class.

However, participants did not only resist the identity of being ‘old’, but instead, experienced their personal and social identities in more complex, multiple, and at times, contradictory ways. This was especially evident in the way participants both identified with and distanced from the social identity of being ‘old’, for example, Sylvie explores her sense of age and ageing in relation to visual image one<sup>28</sup>:

*I think they are older than me. They may not be. But they feel older than me  
and I don't feel like that at all ... I think what I am getting at, it is bit of a  
mean thing, I don't like to categorize myself as 'old', now I am in that box in  
one sense, but I don't want to be in that box*

(Sylvie, aged 52 years)

Within this quotation it can be seen how Sylvie first distanced herself from the identity of ‘old’, by saying how the couple look older than her, she did not identify with that category. At the same time she realised that ‘in one sense’ she was in the ‘box’ associated with being older but she distanced herself from this image and identity. Other participants questioned the nature of an ageing self after seeing reflections of their (outer) bodies. For example, Angela and Sid described a shopping trip in relation to their own meanings of growing older:

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<sup>28</sup> See visual image one (appendix three).

Angela: *74. Something I never consider really.*

Sid: *You don't think of yourself as being that do you?*

Angela: *You don't feel mentally any different than you were at 24, in any way, and yet you have got years of experience. As you said before you find you can't do things that you used to or you find them more difficult. But you are the same person. Nothing changes.*

Sid: *You see yourself in a shop window or something*

Angela: *Yes you see an old lady going along*

Sid: *You see this old boy going along these and suddenly it comes to you it is yourself*

(Angela, aged 78 years and Sid, aged 80 years, middle class)

Within this quotation it can be seen that there was a tension between the more enduring and youthful sense of self in contrast to the reflection of the 'old lady' and 'old boy' mirrored in the shop window. So whilst Angela appeared to some extent to distance herself from the social identity of being 'old' at the same time she recognised that the self has also changed due to her '*years of experience*'. The sense of subjective self was therefore not constant as the significance of increased knowledge and experience when older was also recognised:

*In the old phrase I wish I was a little bit younger and knew what I know now.*

*I don't really think an awful lot about age as such. I mean the years come and the years go and as long as I feel reasonable with myself I am OK. And I am lucky that my hair hasn't changed colour so that I am not obviously ancient*



*by the grey or white hair. But I don't think it would bother me that much. I would never bother dying my hair. I am not that vain .. I just get on with life*

(Anna, aged 67 years, middle class)

The knowledge and experience gained over years allowed participants, especially the women, to gain confidence in their embodied selves as they age: the experience of ageing was not only negative. Negotiating an identity in relation to age and ageing therefore involved a complex process of exploring a sense of self, experiences of the lived body and associated imageries and discourses of embodied 'others' within the participant's social worlds. It could therefore be anticipated that older people's social identities were complex, and at times contradictory, as the sense of self and the lived body, within certain limits, were experienced in continual flux as shown by their experiences of the lived body as an absence / presence, an in/visible entity within their everyday worlds. Participants therefore both identified with and resisted the social identity of being 'old'.

### **'Doing' and 'Doing 'Less', the Ageing Body and Everyday Life**

The body was a central discourse for the participants when talking about their daily activities within their personal and social worlds. The 'doing' of age, ageing and the body was therefore central to their embodied participation in everyday life. The participants discussed the 'doing' of ageing in terms of loss and / or achievement, body / mind maintenance and bodily limitations to daily activities. Underlying the praxis of the ageing body were moral discourses associated with active versus passive embodiment, control of an ageing body in (inevitable) decline, and a sense of stigmatisation associated with bodily limitations, weighty bodies and 'doing' less.

The participants further experienced their bodies as a taken for granted aspect of their everyday lives until moments and / or times when an awareness of their body disrupted daily activities.

When discussing their experiences of ageing the participants frequently expressed their sense of loss in terms of bodily limitations and the experience of slowing down and / or ‘doing’ less. These changes to their bodily experiences were associated with a loss of activities, associated symbolic material losses, such as golf clubs, loss of self esteem, a sense of regret and disappointment, and for some participants a sense of stigmatisation that at times further limited their participation in everyday life. For example, Ken talked about his bodily limitations in terms of ‘slowing down’ that restricted his performances in everyday life:

*Ken: I am only conscious of the fact that I am getting old. I don't want to feel it. And to a certain extent I regret it. I would love to go back 20 years and continue doing what I was doing then. Had the motivation that I had then. Having the ability to do then, to be able to what I was doing then.*

*Int: 'What do you see as the difference then?'*

*Ken: I am slowing down. It is only very gradually. I don't often think about it but when I do I get a visual age; that age is creeping up on me.*

(Ken, aged 64 years, middle class)

The physical performance of the body was especially significant to the men's perceptions of growing older, in particular, the functionality of the body associated with increasing bodily limitations. For the men, the experience of ‘doing’ less was



received with a sense of ‘regret’ and disappointment. For example, Ian described his sense of loss for activities he used to enjoy:

*Well the disappointments of age are increasing. I haven't found any ways of making it reduce. And it really means you get to the stage where you can't do what you used to. I don't do my respiration any good by smoking, but I smoke, but it does mean that I haven't played golf for 3 years. If I play 15 or 16 holes, I want to pack it in. I am tired. So I hadn't played for about 3 years. A week ago I sold my golf clubs.*

(Ian, aged 69 years, middle class)

For Ian, selling his golf clubs was a significant moment as it was a visible recognition that his body was no longer able to sustain the activities that he once enjoyed: a symbolic loss of competition (and winning) that was central to his (masculine) identity. Whilst Ian acknowledged that certain lifestyle choices, such as smoking, may further restrict his bodily possibilities, underlying his discourse is the idea of ageing as an inevitable process of biological decline. This decline can be experienced as a sense of loss for activities that were once enjoyed. Everyday limitations to bodily performance were further described by Gordon:

*It means the things you used to be able to do you can't anymore, like run up the road and not get out of breath. I don't mean just up the road, I mean a couple of miles to the shops whatever .. I haven't got the stamina*

(Gordon, aged 68 years, middle class)

As the power and endurance of his body had diminished with chronological age, the previously taken for granted walk to the shops had become more evident. For Gordon, his bodily experiences, being ‘out of breath’ and with less ‘stamina’, had

intruded into his everyday life. Growing older in male bodies was therefore associated with loss of bodily power, stamina and the ability to continue with certain physical activities.

‘Doing’ less was further related to increasing chronological age. Catharine reflected on bodily changes that have progressively impacted on her everyday life:

*Oh it is horrible. What do you expect it to be? It is funny this, up to 75 I didn't feel old. I could do all sorts of things, and people thought I was a lot younger. And from 75 onwards gradually, gradually you decline. Going up the stairs, up to 75, I got up quite quickly. Now I crawl up the stairs. I need a great deal more sleep than I used to need. For instance there was nothing on television last night. I went to bed at half past nine. I don't like being 83. Who would? But then I am grateful to be 83 if you know what I mean.*

(Catherine, aged 83 years, middle class)

Catharine interpreted her chronological age in terms of ‘doing’ less, a process of gradual decline, in which her habitual daily activities had become more challenging. These bodily changes were further compared to her abilities in relation to previous chronological ages when her body was a taken for granted presence within her everyday life. In particular, it was evident that participants aged 80 years and over, frequently referred to being ‘old’, and described more losses in relation to their everyday activities. Many participants further described growing older in terms of a process of generally slowing down associated with diminished energy levels, a tendency to sit down more and a feeling of increased tiredness. Angela and Sid, for example, described how they rest more now they are older:



Angela: *You don't have the same energy as you get older and it begins to strike you aren't getting any younger*

Sid: *You sit down more*

(Angela, aged 78 years and Sid, aged 80 years, middle class)

The need for more rest was seen as inevitable part of growing older. The experience of 'slowing down' would further influence the everyday activities of the participants:

*It takes a bit longer. I mean we had this thing about the amount of work he can do, in the garden, and shopping and whatever, but I said the housework takes longer than it used to. Everything takes longer as you get older, and if you have got more time, you use more time.*

(Susan aged 64 years, middle class)

The experiences of 'doing' less was associated with gender, in relation to the type of activities undertaken that map onto the gendered nature of public and private spaces. When participants talked about their embodied practices of daily life, the women more frequently referred to the family, the home and 'doing' housework. In contrast, men talked about sport, gardening, walking, and being in paid work. The praxis of the ageing body was therefore gendered and differentiated in relation to the use of social space: public space predominately being the male domain, and private space predominately the female domain. In this context, the praxis of growing older was in gendered ageing bodies and performed in gendered social space.

The participant's embodied experiences were further influenced by changes in their biographies, for example, retirement and changes to their family life. In particular, the types of embodied activities changed:

*Well because when I retired I wasn't getting any exercise in the winter, because in the summer, you are out gardening and, you know, washing curtains, and all this sort of thing, but in the winter, I was sitting in and reading books all the time*

(Joanna, aged 68 years, middle class)

Following retirement, changes in temporal and spatial daily activities, household structure and the influence of different seasons, impacted on the activities of everyday life. A number of participants described that now they were 'doing' less:

*I am more lazy than I used to be. Because if we have been out all day, we have got all the things to do when we come home, but when you are here all the time, unless there is something specific, the day is like that, and you can choose how you spend it. And I rushed around for 40 years looking after the family, and I am slowing down now in some things.*

(Anna, aged 67 years, middle class)

Many participants found that as their daily schedules changed that there were corresponding changes to their bodily experiences, for example, feeling stiffer, aches and pains and reduced functionality of muscles:

*My muscles were disappearing, there was nothing there, and I was finding it difficult to lift things, and you know .. I suppose it happened over a number of years, but when I stopped working, I used to heave tables about and move chairs.*

(Barbara, aged 66 years, middle class)

It was therefore also a combination of changes to the biographies of the participants and the associated transformations to temporal and spatial dimensions of everyday



life that led to a process of ‘slowing down’ and ‘doing less’. However, whilst there was an acceptance of these embodied changes, and the need for more rest, many participants also viewed this as an indication to actively increase bodily activities. For whilst ‘doing’ less was viewed as an expected and inevitable part of growing older, some participants were reluctant to ‘give into’ these embodied sensations:

*I am always tired. I am tired, I feel weary. I don't ever sit down, that is the thing. I won't give into it.*

(Tracey, aged 59 years, middle class)

Allowing the body to slow down and be passive in later life was actively discouraged. Whilst the ageing body was experienced as ‘slowing down’ there was an alternative discourse about the importance of keeping active in later life. Underlying ‘doing’ the ageing body in everyday life were therefore moral discourses between active and passive embodiment. For example, Penny described how despite her embodied experience of tiredness that she continued to keep active throughout the day:

*I mean in the winter, perhaps I might watch something, not usually before three in the afternoon, but I feel almost guilty about that. I feel I shouldn't. To me that is the downward slope if you start watching telly during the day, you talk about people, sort of being old, and doing nothing. You know to me that is the beginning of it. Sometimes I get tired. But I would not go to sleep in the afternoon because to me that is as bad as watching telly in the day time.*

(Penny, aged 63 years, middle class)

The body needed to kept active, and body work was central, in order to avoid the perceived negative consequences of ‘old’ age, described by Penny as the ‘downward

*slope*'. Tessa also highlighted the possible consequences of not being active in later life:

*When you get older you must never sit, when you retire you must never sit down, and look at a book, because you put on weight, and your body gets all, you know, you can't walk, and everything.*

(Tessa, aged 66 years, working class)

Keeping the body active was often summarised within the term 'if you don't use it, you lose it'; referred to in relation to both an active body and an active mind:

*We need to keep active. It is like anything. It's like your brain power, if you stop using it, you lose it.*

(Susan, aged 64 years, middle class)

So whilst there was an underlying sense of the inevitability of 'old' age it was viewed as a moral requirement to keep active in order to ward off perceived negative effects and imageries of 'old' age (cf. Williams, 1990). Body work, and activities to promote the body and mind, were actively encouraged. There was a conscious effort to keep active within the context of daily life that progressively increased as the participants grew older:

*I suppose years ago, 80 well it was, really, really, you can't believe it, but it isn't like it used to be like. But you try and keep your mind active, as I said before, by reading the newspaper, and luncheon meals, and things like that. Doing crosswords, you don't want to start sitting in the corner. But you could easily do it you know.*

(Fay, aged 80 years, middle class)



*I like the afternoon programmes. I never put it on until, I like to watch Countdown. I like to watch quizzes. Because I think it is good for you to try and answer the questions. I think it makes your brain work, and I don't want it to get addled.*

(Margaret, aged 87 years, working class)

Daily activities within the everyday lives of the participants were chosen as a way to maintain an active mind and body. There were temporal and moral dimensions to these activities, in which leisure activities became reinscribed as body work: reading a newspaper in order to maintain an active mind and social engagement; and watching quizzes as brain 'work'.

The performance of the body within the everyday lives of the participants was therefore important and there was a corresponding sense of stigmatisation associated with bodily limitations that were associated with 'old'. This sense of stigmatisation was experienced in terms of guilt and / or a desire to hide visible bodily limitations from public social space that, at times, further restricted participation in social activities. Stella, for example, had severe breathlessness that impacted on her daily activities. She described her sense of 'guilt' at having to stop whilst shopping:

*Stella: So we walk slow, and I stop, and I am always guilty of stopping, it is funny. So I look around.*

*Int: Why do you feel guilty?*

*Stella: Yes, because I can't breathe, and everybody else is rushing along. It is strange. It is something you think, you know, people think what is the matter*

*with her. So I stop, and pretend I am looking at the birds, or the trees. It is silly I know.*

(Stella, aged 73 years, working class)

Within the discourses there was a sense of avoiding being seen as dependent and / or in decline when ‘doing’ old age: the negative consequences of ageing bodies were to be hidden from public view. Some of the men expressed their reluctance to ask for assistance with manual work that related to their sense of masculinity:

*You feel guilty, or I feel guilty, with having to ask someone to do something. I mean, I could even ask you, which to me is completely wrong. You shouldn't ask a lady to do something manual, you should do it.*

(Sid, aged 80 years, middle class)

Negative aspects of ageing bodies were, moreover, to be bounded with certain social space, in particular, the spatial limitations of the home. Rachel, for example, described how she hides experiences of ‘off days’:

Rachel: *If I have an off day then I don't get dressed.*

Int: *What do you mean by an off day?*

Rachel: *Well if I don't feel 100% for any reason. I don't tell anybody, and I just sort of, wander about in my dressing gown, wander around, and go back to bed early.*

Int: *Do you do that often?*

Rachel: *No every couple of months or so. Being lazy.*

Int: *Why do you call it being lazy?*

Rachel: *Because I want to stay in bed.*

(Rachel, aged 77 years, middle class)



Within these discourses about ‘doing’ less there are alternate discourses between active and passive embodiment. For whilst resting was to some extent an acceptable and inevitable aspect of ageing, the experience of being passive was frequently described as ‘lazy’, and being seen as ‘lazy’ was to be actively discouraged. Some participants would therefore prefer to hide their bodily limitations, pain and dependence from public view: that frequently meant within the home. Ivy, for example, described how she avoids going away on holidays as she is concerned that she will disrupt the sleep of others:

*It is difficult at the moment only in the fact that I can't have a holiday you know this year. It hasn't bothered me normally I had had two or three holidays a year and because of my hip I haven't gone to stay with friends. I have been invited but I usually have two or three holidays and I am away several weekends visiting my friends and I don't want to go. I want my own bed and the raised toilet seat and things like that at the moment. I know if I have to get up in the night I disturb people and they come and start fussing. So I stay at home at the moment.*

(Ivy, aged 71 years, middle class)

Ivy prefers the comfort and privacy of her own home as she manages her painful hip. However, the spatial dimensions of hiding bodily limitations, were also related to the participant's locality. Kate, for example, described how she prefers not to use a walking stick within her neighbourhood, but will happily do so on holiday, where she is not known:

*I can walk up hills and steps, but coming down, that is very, very difficult. Very difficult. Mostly when, not here, but if we go like Devon or somewhere, I have a stick, don't I. I have got too much pride to use one here.*

(Kate, aged 70 years, middle class)

Due to a sense of stigmatisation participants withdrew further from certain social activities that they may enjoy. In particular, the perceived negative consequences of being 'old', bodily limitations, aches and pains, a sense of dependency, and generally 'slowing down' were hidden from public view. Undisciplined 'old' bodies were therefore both resisted and concealed.

The performance of the ageing body was not only conceptualised in terms of loss but also as a sense of accomplishment. Competent performances of an ageing body were viewed as an achievement:

*You asked me what it is like to be 71 I have tried to be as physically fit as I can. And I feel as though I have achieved something ... I have had a very good life living to be 71.*

(Marilyn, aged 71 years, middle class)

Marilyn sees that living to 71 years, and maintaining a good level of fitness, evidenced by attending keep fit classes, as an achievement gained through actively working and maintaining the ageing body (cf. Shilling, 1993). Body maintenance was important for many of the participants that involved actively taking exercise. The types of exercise identified included walking, walking the dog, yoga, keep fit, exercises in their own home, cycling, the gym, swimming, gardening, badminton, and golf. A few participants continued competitive and team sports, such as badminton,



but the majority of types of exercise were individualised. Perceived bodily benefits of exercise included increased suppleness, body toning, agility and a means to control body weight. A disciplined active body was therefore an effective way to prevent the perceived bodily effects of ageing. For example, some participants described how exercise prevented the stiffness associated with growing older:

*I wanted to keep supple. I didn't want to get too stiff. Really, as I say, it was just one of those things, as well, I just wanted to do yoga. And we always have had a dog*

(Pauline, aged 61 years, working class)

*I find I am getting a little stiff, and I say I am off for a walk, and I am alright after about half an hour. Hour. If I walk.*

(Clive, aged 73 years, middle class)

Other participants described the importance of a disciplined and toned body. The appearance of the ageing body was important to the participants. For example, Tony described how he compares his toned physique to other men in the changing room of the sports centre:

*It keeps your body toned up. Because I mean, you have only got to see, I mean, I notice blokes all stripped out, and that they are all sagging. You know it is only because of lack of exercise, that is all it is. And as your body gets older it does sag.*

(Tony, aged 78 years, working class)

Comparisons with the bodies of others at similar chronological ages were often made to emphasise the perceived benefits of exercise:

*It keeps me supple. And the fact that I have a number of friends the same age as me who definitely aren't, I know being fit is looking at a person, and I look at me in the mirror, and I can walk faster than a number of people, and I think to myself, I have done the best I can.*

(Marilyn, aged 71 years, middle class)

An exercise regime maintained a toned and supple body and was also viewed as an important way to prevent weight gain that was associated with growing older:

*Yes. Because I want to get rid of, I had a, I was getting a bit of a stomach, and I have been very conscious of my figure. So I lost my waistline, and I said I had to do something about it, and of course, it keeps me agile.*

(Sophie, aged 78 years, working class)

*I would certainly put weight on if I wasn't so active. So I mean I enjoy it, if I didn't enjoy it I wouldn't do it. I walk quite a lot with the dog as well, you know, she gets 2 walks a day, so, I make sure I get exercise, it keeps me toned, well bits of me toned. There are some bits I would like to work on but as long as I keeping at a reasonable weight. I am one of these who can put on weight if I am not careful.*

(Nicole, aged 50 years, working class)

Nicole maintained a very disciplined bodily maintenance regime that included participating in a variety of exercises, such as yoga, the gym, waking, cycling and swimming, and kept strict control of her dietary intake. The main motivating force behind this regime was to control her weight and therefore promote her sense of well-being. There was a sense of stigmatisation around gaining weight; and attempts to avoid weighty bodies were via a disciplined body maintenance regime in everyday



life (see chapter 5 for a wider discussion about gender and body weight): bodily appearance and performance was important to the participants.

Exercise was also a strategy for maintaining a sense of well being, as well as promoting an active body and mind. Anna, for example, described the benefits of line dancing:

*It is quite energetic. But it is good fun. You are learning new dances all the time so it is not only good for you physically. It is good for you mentally because you have got to remember the dances as well*

(Anna, aged 67 years, middle class)

Moreover, exercise was associated with promoting mental as well as physical well being for some participants. This was especially referred to by the women in relation to yoga:

*I feel, I feel physically good, when I have done a yoga class. It is probably the endorphins or something isn't it? Probably like chocolate. But I do, there is a physical high when I have done a class, which is a nice thing to have and I can feel that. I also think it is because you have to work hard both physically and mentally, and especially mentally, because it is a very mental thing yoga. And you are busy working which means that you are not worrying about other things that might be going on*

(Sylvie, aged 52 years, middle class)

Exercise was a way to reduce stress as well as promote a sense of embodied well-being; many participants described how exercise took them away from the everyday

concerns of life. Performance of an ageing body therefore also promoted a sense of self worth and identity.

At the same time there were limitations to the changes that participants wanted to achieve with their bodies. In particular, there was a concern that the appearance and performance of ageing bodies, as viewed in the public world, were age-appropriate. Many participants, for example, expressed a concern to be seen in age-appropriate clothing:

*Let's face if your body has gone south a bit. And why shouldn't we have – this sort of shade that would suit you, it is pretty, it is uplifting – you don't. Why should we suddenly be of a certain age – not segregated, but your face isn't as supple, as young. So OK, we still want to look good but not ridiculous*

(Peggy, aged 67 years, working class)

The participants, in particular, expressed the concern to be seen in appropriately aged attire whilst at the same time ensuring that their outer bodily appearance appeared disciplined and attractive. In this context, outer appearance and clothing also promoted a sense of subjective well-being amongst the participants:

*It is about how I feel, how my clothes fit, and that, you know, if I am completely honest about it, yes, it does make me feel good*

(Patrick, aged 64 years, middle class)

Participants did however also describe generational changes about the appearance of ageing bodies in public space:

*Always looked like an old man my granddad. Now in the summer I run around with shorts and T-shirts and a pair of sandals. I don't think my dad would*



*have. But he was very ill in the year before he died, very ill. I think he would have relaxed a bit, but you see people of my age, and they are walking in shirts and T-shirts, and you never would have seen that years back*

(Harry, aged 67 years, working class)

Age appropriate clothing and demeanour therefore was contingent on generational and social factors that changed over time. The performance and appearance of the ageing body was therefore central to the participant's sense of well-being, identity and conduct within their everyday lives.

#### Concluding comments.

There were two analytically distinct ways in which participants articulated their embodied participation in their social worlds: the experiences of and the 'doing' of age and ageing in everyday life. Whilst these distinctions may be discursively and analytically distinct, within the context of the participant's everyday lives the experiences and 'doing' of the body were instead interrelated in complex, and often contradictory, ways.

First, participants talked about their experiences of age, ageing and the body in everyday life. These experiences included the significance of bodily metaphors and bodily signifiers associated with old age, a questioning of the elasticity of the body, an underlying notion about the inevitability of ageing and contrasting discourses between body / mind, inside / outside the body and a youthful subjective self within an ageing body. Many participants experienced their bodies as a taken for granted aspect of their everyday lives until moments and / or times when an awareness of the

body interrupted their daily activities. This was especially evident when participants experienced changes to the lived body, for example, ill-health, aches and pains, bodily limitations, diminished energy levels and / or signifiers of ageing, such as wrinkles, increased body weight and/or greying hair. Alternatively bodily transformations were reflected back to the participants via visual and discursive images, from corresponding physical changes amongst family and friends and / or from glimpses of their own bodies in mirrors. It was at these moments when the everyday visibility of the body was heightened and the participants reflected on their own meanings and identities associated with growing older.

Second, participants discussed the ‘doing’ of age, ageing and the body in everyday life. The body was a central discourse for the participants when talking about their daily activities within their personal and social worlds. The ‘doing’ of age, ageing and the body was therefore central to their embodied participation in everyday life. The participants discussed the ‘doing’ of ageing in terms of loss and / or achievement, body / mind maintenance and increased bodily limitations that impacted on their daily activities. Moreover, underlying the praxis of the ageing body in everyday life were moral discourses associated with active versus passive embodiment, a sense of stigmatisation associated with bodily limitations, weighty bodies and / or ‘doing’ less. The performance and appearance of the ageing body in social space was therefore also central to the participant’s sense of well-being, identity and conduct within their everyday lives. In particular, the everyday visibility of ageing (Gubrium and Holstein, 2003a) was heightened when experiences of the lived body disrupted the taken for granted nature of daily activities.



A focus on the lived body has therefore shown that, like pain and chronic and illness (Bendelow and Williams, 1995; Williams and Bendelow, 1998), that the body was a taken granted aspect of everyday life until disrupted by experiences and the 'doing' of growing older. The increased visibility of the ageing body was given meaning and expressed via discourses associated with active and passive ageing. The control of bodily boundaries became increasingly significant within the participant's everyday worlds. As the following chapter will show these concerns were also central to emotional experiences in the context of everyday life and at critical moments.

## 4

### **Emotions, Bodily Boundaries and Identity in Everyday Life**

*No one ever told me that grief felt so like fear. I am not afraid, but the sensation is like afraid. The same fluttering in the stomach, the same restlessness, the yawning. I keep on swallowing.*

*At other times it feels like being mildly drunk, or concussed. There is a sort of invisible blanket between the world and me. I find it hard to take in what anyone says. Or perhaps, hard to want to take it in.*

(C.S.Lewis, 1961, *A Grief Observed*)

Emotions were interwoven throughout the everyday discourses of the participants as they described their experiences of everyday life, their biographies, and their social interactions. In particular, there was a continual tension between inner (private) subjective feelings and *experiences* of emotions and the outer (public) bodily and spatial *expression* of these emotions. This tension was felt most acutely and intensely at critical moments within the participant's biographies, such as, bereavement, divorce and retirement, when emotions and emotional experiences were heightened, uncertain and fluid. This signifies the way the experience and expression of emotions were mediated by the socio-cultural context in which they occurred.

The focus of this chapter therefore is to explore the lived experiences of emotions as articulated by the participants within their everyday lives. In particular, the personal



and social meanings that the participants associated with their emotional experiences and expressions within everyday life will be highlighted. Emotions, by their very nature, are complex, moving, slippery phenomena to describe, discuss and analyse and the participant's narratives highlight this complexity (cf. Lupton, 1998; Williams, 2001). These intricacies are further complicated by the web of social relationships and interactions within which the participant's emotions were embodied and embedded. Emotions, identity, and social interaction therefore were interconnected throughout the participant's biographies, their everyday lives, and lived through their bodies. In recognition of these analytical and existential complexities, this chapter will explore the emotional experiences of people in later life thereby gaining insights into their public and private social worlds.

The key themes presented in this chapter emerged predominately in the context of the in-depth interviews and it will be shown how the participant's biographies were central to understanding their emotional worlds and identities. The data as such will be quoted *verbatim* to show the complex relations between the experience and expression of emotions within the social context. Participants moreover continually said they rarely had opportunities to express painful and complex emotions within their everyday lives. Within the private, bounded and confidential context of the interviews however many participants felt able to share some of these painful and difficult emotional experiences with me as a researcher. It was therefore my responsibility, as a researcher, to ensure that their voices were heard within the public world *in their own words*. In this way significant insights into the everyday emotions and emotional experiences of people in later life can be gained that may start to lift

the veil from the ‘mask’ of ageing and promote our understanding of their subjective worlds.

The significance of emotions within the biographical interviews may further signify a process of reflexivity and emotional work that people in later life experience in the context of an ever changing and uncertain social world. Growing older may be becoming a more reflexive, complex and diverse experience. Research moreover is an inherently social, reflexive and active process in which my own biography, emotions and experiences interweaved with the participant’s experiences and discourses. The role of emotions was significant throughout the research process, both for the participants as they engaged with complex and painful memories, and for me as a researcher, listening and later analysing these stories. The data presented in this chapter is therefore co-constructed between me as a researcher and the participants. The personal and social meanings described by the participants about their emotional participation in their everyday worlds will now be explored.

### **Emotions in Everyday Life**

The expression and experiences of emotions were articulated in the context of the everyday lives of the participants. In particular, emotional discourses emerged in the context of the participant’s perceptions of their own characteristics of self, embodied sensations, within social interactions, in relation to ideas of coupledness, and strategies deployed by the participants to avoid experiencing and expressing negative emotions and feelings. Two issues emerged in the context of the participant’s everyday



emotional discourses: (1) bodily experiences and expressions of emotions; and (2) promoting emotional well-being: age, identity and social networks.

### Bodily experiences and expressions of emotions

Many participants considered emotions to be an important aspect of their everyday life. Their emotional experiences were frequently described in relation to perceived characteristics of self, such as, *fiery*, *volatile*, *emotional*, *business-like*, *calm* and *straightforward*. Whilst all the participants articulated the importance of emotions, women participants more frequently described themselves as ‘emotional’, and the men were more likely to see themselves as ‘businesslike’ and ‘straightforward’. The term ‘emotional’ was also always associated with high levels of bodily expressions of emotion, such as, crying and anger:

Catharine: *But I see things on the television and I am sitting there. Boo hoo.*

*Stupid me. But I would rather be like that then be hard hearted. Definitely. I would rather be concerned.*

Int: *Does it worry you being emotional then? Or do you see it as a positive thing?*

Catharine: *No I don't worry about it at all. As I say I would much rather be emotional, and show my feelings then keep it all bottled up. Because I think if you don't show your feelings, you get a certain hardness in a way. I mean I don't go round to people, and say, oh God, so and so happened, blah, blah, blah, blah. I don't. But if I am distressed about something I will weep. If I think something is very funny then I laugh. If something annoys me then I am*

*cross. I have got all the emotions of everybody else.*

(Catharine, aged 83 years, middle class)

Catharine points to both positive and negative emotional experiences and further associated her bodily expressions of emotions, weeping and laughter, with her emotional experience at that time, respectively, being in distress and finding something funny. Being 'emotional' was further seen as an important character trait that promoted her sense of self. Emotions are, moreover, not to be kept 'bottled up', and many participants described the alternative bodily expressions of keeping emotions 'inside' the body or letting them out. For example, Susan and Peter both described themselves as '*volatile*':

Susan: *I think I let my emotions come out. It depends what it is I might stamp and shout.*

Peter: *We are similar in emotions for example.*

Susan: *Yes we are.*

Int: *You both let emotions ..?*

Susan: *Yes we are both quite volatile*

Peter: *It's the red hair you see.*

(Peter, aged 66 years and Susan, aged 64 years, middle class)

Many of the participants signified that certain prompts would trigger an emotional reaction. For example, when discussing the importance of emotions, Pauline articulated how memories triggered by looking at a photograph album resulted in her crying and the bodily expression of her feelings:

Pauline: *In fact the other day, I was feeling a bit down in the dumps, so I went upstairs, and got all the old photographs out, which didn't help at all, because*



*I ended up sitting up there, blabbing you know. But yes.*

Int: *Photographs of your family or...?*

Pauline: *Yes just general photographs of the family, mum and dad and things. In fact, in the box, that was in there, was my son's card, that they have as children, so that box was up there, and our wedding day cards, and that sort of thing. My 21<sup>st</sup> birthday cards were up there, that I had forgotten about, from all the aunties and uncles that are not with us any longer.*

Int: *Were you crying with sadness?*

Pauline: *I was sad because the aunties and uncles aren't here. My mum was the eldest of nine, and there is only one left now. Only one alive. And that is sad, but then, of course, you have got to expect it.*

(Pauline, aged 61 years, working class)

In contrast, to the bodily expression of emotional experience, some participants, in particular, a number of the men, described how they concealed their emotions. Ian, for example, explained how his wife sometimes saw his attitude as 'cold', whilst for him, not showing any emotion was a way of controlling situations both in his public and private space:

Ian: *Um yes, many years ago, Marilyn described my attitude, to a serious difference of opinion, as me going coldly horrible. But the reason for that, in a domestic situation, was that I never felt there was any value, other than one of having a fight, and the one was just to satisfy the sense of the one that was doing it.*

Int: *And you would keep calm?*

Ian: *Yes I was accustomed to keeping calm. If you are sitting in an office,*

*on your own behind your desk, and you had an arc of nine staff, representatives from the association of supervisory technical and management staffs, all trying to defeat you in negotiation. The last thing in the world you can do is allow emotion to creep into the situation, even if you felt angry about what they were trying to say. If you lose it, you are an idiot, and you weren't negotiating professionally. And I was accustomed to thinking and being that way.*

Int: *And so you played that into your home as well?*

Ian: *Yes insofar, not because it was a business attitude, but because it was a natural attitude.*

(Ian, aged 69 years, middle class)

For Ian, not allowing '*emotion to creep in*' was central to maintain his own bodily presentation of self. The trait of not being 'emotional' was seen as either a familial or 'natural' characteristic for men. Of note, when describing masking emotion in everyday life, the men who described themselves as 'unemotional' were predominately talking about rather than expressing anger, and anger was the main emotion that the men described. The concealing of anger did however require emotion work to keep intense emotional sensations within masculine spatial and bodily boundaries. Clive, for example, described the work required to hold his emotions '*inside*' rather than engage in any direct confrontations:

Clive: *I don't see any point in it. I say life is too short, and people say things that they don't really mean on the spur of the moment, and it is all right if you are the type of person, that you can up with it, fight it, and immediately afterwards forget all about it. I can't do that. So I don't start one.*



Int: *How is it for you then? Do you find it difficult to move away from it?*

Clive: *No I just go quiet and play three monkeys.*

Int: *You go quiet. Do you hold it inside somewhere?*

Clive: *Yes.*

Int: *And how does it feel when you hold it inside?*

Clive: *Well I don't mind because that is in my makeup. All my family, the catholic if you like, the catholic, never any of them show emotions. My father's side. Never showed any emotion at all. Everything was dead straight forward. Straight as a die, everything was straightforward.*

(Clive, aged 73 years, middle class)

For Clive, not showing any emotion was part of his bodily '*makeup*'. Emotions were contained within the body by actively going quiet and holding in bodily sensations. Of interest, later in the interview, despite the embodied constraint of emotional expression described above, Clive does point to occasional and sudden outbursts of anger:

Clive: *But I don't suppose I lost my temper more than about six times.*

Int: *What do you mean when you say lose your temper?*

Clive: *Get really wild and angry.*

Int: *Right. So you do sometimes?*

Clive: *Oh yes I do, but it takes a lot to get me going, but usually it is a little thing. It is some little thing. And I just go. And once it is over and done with, I have finished with it.*

(Clive, aged 73 years, middle class)

So whilst Clive contained his anger *inside* his body there were moments when he became ‘*wild and angry*’: bodily expressing his emotions previously withheld. The term ‘wild’ is interesting implying a natural, bodily reaction, a loss of emotional control, that had in fact been triggered by ‘*a little thing*’. The idea that emotions build up in the body, if they are not let out, was central to the emotional accounts of everyday life. At the same time the transient nature of emotional experiences from moment to moment and day to day was also recognised. The everyday expressions of emotions were also gendered: women were more likely to express emotions and be seen as emotional.

Promoting emotional well-being: age, identity and social networks.

Participants described the importance of maintaining emotional equilibrium in their everyday lives. In particular, a number of the women described the importance of subjective feelings associated with ‘being happy’ and ‘content’:

Int: *Being happy is that important to you?*

Ivy: *Yes.*

Int: *What does that sort of mean?*

Ivy: *Being content you know with what you have got I suppose.*

(Ivy, aged 71 years, middle class)

Finding a state of being and feeling happy and content was important for the participants. Although due to the transient and fluid nature of emotions this emotional state was difficult to maintain at all times. Expectations of happiness also lessened as the participants grew older:



*Yes I think my life is happy. I am happy for one my age.*

(Catharine, aged 83 years, middle class)

Although difficult to express sometimes participants did articulate personal and social meanings associated with emotional well-being. This can be illustrated by Derek's response to the visual image of a woman holding a laptop<sup>29</sup>:

*Well this reminds me of what the drop in centre is all about. It is the fact, that it is an old lady, who is showing a childish expression of excitement, because she is feeling the excitement that a child feels of discovering something new. She is able to do it, and she has discovered something she didn't know before.*

(Derek, aged 67 years, middle class)

Derek described a sense of '*emotional excitement*' from learning something new and related this to his own biographical experience of paid work. The emotional experiences of 'excitement' and 'delight' were further associated with the bodily demeanour and facial expressions of the woman in the visual image<sup>30</sup>:

*Oh she has got a laptop. Speaks for itself. She has got a very, she wants to continue learning, and takes a delight. This lady is finding something new, you know, she is absolutely delighted. Oh I have done it. That kind of thing. And it reflects in everything. It reflects in her face, the way she dresses, everything.*

(Sophie, aged 78 years, working class)

Both these participants emphasised the embodied nature of emotional experience, feelings of being 'happy' and 'excited' were visibly reflected in (outer) bodies. The

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<sup>29</sup> See visual image eleven (appendix three)

<sup>30</sup> See visual image eleven (appendix three)

participants further recognised the sensations associated with emotional well-being from their own emotional experiences. Enjoying life, learning, and having ‘fun’ were important.

Some participants said that their emotional responses had changed as they grew older, in particular, they became less confrontational and angry. A sense of emotional balance was further associated with an increasing sense of inner confidence:

*My inner soul. I must admit, I can walk away from an argument now, where as I would have gone door slamming. Whether that is your inner soul, I don't know. What is your inner soul. I am me. I know I am me. I am not going to change at my age. So I suppose, I have found my inner soul. I don't know. And I personally, if people don't like me the way I am, then that is their tough luck. It is not down to me to change.*

(Pauline, aged 61 years, working class)

*Well I suppose I have mellowed as the years have gone by. I had a bit of a temper when I was younger, I could be quite fiery, and so always quite brusque, in talking to people.*

(Janet, aged 61 years, middle class)

Growing older was associated with a stronger sense of self, especially for the women: some participants felt more in control of their lives and emotions and / or less worried about the reactions of others. Other participants, especially working class participants, had a sense of resigned acceptance about their situation in life. For example, Harry had retired early due to a back injury and experienced continual physical pain and limited mobility:



Harry: *Well, one time I was quite upset about it, but it don't bother me a lot. Just part of life. You know, it is all you can do, isn't it. You can't be bitter about it. I suppose I might have been at one stage.*

Int: *Bitter about?*

Harry: *Not being able to do things. You know not being able to work and, even decorating, or anything like that, you just can't do it.*

(Harry, aged 67 years, working class)

Despite being in continual physical pain, Harry had developed a sense of resignation with his current situation. Participants with limited financial resources often described a sense of acceptance with their 'lot' in life; opportunities and possibilities for change were not often considered possible.

The women participants frequently related their sense of subjective well-being to their engagement with social networks, their family and partners. Both the women and the men agreed that women tended to carry the burdens of worry related to family issues and the associated emotional work involved. In order to recuperate from the emotional responsibilities of self and others, some of the women participants talked about creating space for private reflection and recovery. Sarah, for example, described how she enjoys an hour on her own before she goes to bed:

*But I quite like that hour. I don't know why I just like that bit of peace where there is nobody asking me to do anything, nobody asking or talking to me. If you know what I mean it is just... Yes, because I think it helps you cope. I think it clears your mind ready for the next lot coming in if you see what I*

*mean. Yes. But that hour does help at night. Just that hour on my own*

(Sarah, aged 55 years, working class)

Sarah has a busy daily schedule that includes caring for her grandchild, domestic responsibilities and paid work.

Many of the participants who had lost a partner described a heightened sense of loneliness at certain times within their everyday lives. This included the loss of everyday social contact and interactions; when being with or seeing other couples; from their reluctance to go out alone; environmental factors, such as the weather and seasons, with winter cited as the most difficult time of year due to the inclement weather and the dark nights; and limited opportunities for social interactions due to restricted mobility and financial resources. Furthermore, the social environment that the participants lived in further influenced their emotional experiences. Fay, for example, described how difficult it feels when other tenants in her sheltered housing scheme died:

*Fay: Of course it gets a bit depressing at times when one or two die that you know and you think to yourself, I am eighty. And you are thinking oh dear. There was one gentleman a few months ago, and he had been here from the start. He had been chairman of the residents committee, for years, and he was very much a favourite, but as they say life has got to go on. I mean you want calm, not having cross words.*

*Int: Is it something you think about then?*

*Fay: Hm. You have got to have something. I mean the winter is, but when*



*you are on your own, you feel a bit sorry for yourself at times.*

(Fay, aged 80 years, middle class)

Engagement with social networks, their social environment and experiences of coupledness were significant to promoting a sense of emotional wellbeing. In particular, social interactions, being active and having a sense of purpose and achievement were cited as important strategies to maintain an emotional sense of wellbeing. Active strategies were taken to avoid sensations of loneliness. Sophie, for example, described how she lives ‘*without getting depressed*’ in her everyday life:

*Sophie: I think it is important to be able to still go out and meet people. That is how I get by by meeting people and talking to them you know.*

*Int: Get by. What do you mean by get by?*

*Sophie: Well live without getting depressed you know. And also, also I like to achieve something every day. If I don't achieve anything and I sat in front of the television all day I would be very miserable. I need to achieve just one thing a day.*

(Sophie, aged 78 years, working class)

Many participants described the importance of being in a couple and being in a partnership was viewed as a key way to avoid loneliness. This idea does however rely on the assumption that being in a ‘couple’ relationship is experienced as close, intimate and communicative. In contrast, some of the participants described their relationships as distant. Some participants rarely shared time and intimate space, and some even led separate lives. Being a ‘couple’, whilst feeling alone, highlighted a sense of loneliness, as described by Peggy:

*Peggy: But he is not a doer. He comes home from work, sits and watches*

*television. Weekends over the pub, comes home, sleeps. So I have got that loneliness at the weekend, more so than during the week. Which I find difficult.*

*Int: In what sort of way?*

*Peggy: Well people assume because you have got a husband, you know there is widows, and that they go out and about, but you get this remark, "oh you are lucky you have got a husband". So you don't get asked to join in with things at weekends, because they think because you have got a husband, you are doing things together. And that isn't so in my case. And he is not an agreeable person that you can have friends in. We are chalk and cheese.*

*Int: So you find it difficult in that sort of way?*

*Peggy: Yes. Chalk and cheese. So I tend to be a little lonely. Because he goes off you know. He goes to the pub, comes home, sleeps and then Sunday he is feeling unwell and doesn't want to go anywhere whereas I would like to share my life.*

(Peggy, aged 64 years, working class)

Peggy's emotional and intimate experience of being in a 'couple' is not how others see her everyday life, and as such, this disjuncture limited her opportunities to engage with more social networks at the weekend. Participants who were in distant and difficult relationships expressed a disparity between an 'ideal' sense of coupledness and their everyday life experiences. For example, when looking at the visual image of the couple <sup>31</sup>, Tessa questioned the image of being 'happy':

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<sup>31</sup> See visual image one (appendix three)



*Well they are walking and they are happy ....I think they are happy, but you know looks can be deceiving'*

(Tessa, aged 66 years, divorced)

Tessa had experienced many years of domestic abuse during her marriage and saw a tension between outward (public) appearance of coupledness and inner (private) experiences.

It can be seen, therefore, that emotions, social interactions and identity are inextricably interconnected within the discourses of the participants talking about their everyday lives. Engagement with social networks, their social environment and experiences of coupledness were significant to the participant's sense of emotional wellbeing. There was also an underlying tension between inner (private) subjective feelings and *experiences* of emotions and the outer (public) bodily and spatial *expression* of these emotions. This tension was however felt most acutely and intensely at critical moments within the participant's biographies, such as, bereavement, divorce and retirement, when emotions and emotional experiences were heightened, uncertain and fluid.

### **Emotions at critical moments**

Many participants described their emotions and emotional experiences at critical moments within their biographies predominately associated with a sense of loss, such as bereavement, divorce, being an informal carer, illness and retirement. At these times a continual tension was experienced between their bodily feelings and experiences within their private world and their embodied expression in the public

realm. For participants experiencing bereavement, separation and divorce from a partner this boundary was frequently symbolised within the idea of returning to an 'empty' home. During these times the intense bodily expressions of emotions, such as crying, anger, shouting, screaming, and negative sensations of feeling low and depressed, were limited to their intimate and private space. At times of acute loss when their emotions were heightened, fluid and painful, there was a continual imperative to manage emotions across embodied boundaries and space. In this context, expressions of emotions needed to be controlled within bodily boundaries, that is kept 'inside' the body, and between public / private space, that is within the private realm and hidden from the public gaze. In particular, there were three key themes associated with emotions at critical moments: (1) public and private expressions of emotions; (2) re-negotiating identity; and (3) caring, (ill) health and emotions.

#### Public and private expressions of emotions

For participants experiencing acute loss of a partner, through bereavement or divorce, it was the persistent nature of embodied sensations and feelings, a complex interconnection of thoughts, memories, feelings and bodily sensations, at critical moments that needed to be managed within the participant's everyday lives. Tony, for example, described his feelings following the death of his wife a few years earlier:

*Tony: I know when Joan died it was such an empty feeling. Terrible, empty feeling. Especially when, you know, you are not going to see them any more, you know. It is a terrible feeling. It is awful. I think it is the worse feeling there is, you know, and it is really a mental pain, you know. You can't get rid*



*of it neither whatever you do .. But as they say time heals. And it does. It took me nearly two years to get over it. But you get over it in the end, you know.*

Int: *And when did you start feeling better - what changed for you do you think?*

Tony: *Well, I never started crying when I thought about her, and talked about her. I couldn't talk about her, and I kept on crying, you know, all the time which you do, don't you, and that went on for about three or four months, you know, and then it gradually wore off, you know, and without any sort of help, you know, really. It was just a matter of your body renewing itself, I suppose you would say, really.*

(Tony aged 78 years, working class)

Tony first described the 'empty' feelings he felt following the death of his wife. These feelings were persistent, a continual 'mental pain', and the sign for Tony that he is feeling better is that he no longer 'cries' when talking or thinking about his wife. It is the memories that prompt the bodily expression of emotions, and it requires time for the body to heal, to 'renew' itself. This interrelationship between body, mind and emotions at critical moments is thereby experienced as a continual synchronistic flow of sensations (cf. Williams, 2006). Barbara also points to the centrality of her bodily emotional experiences following the death of her husband and describes when she feels 'desperate':

Barbara: *Sometimes I just cry, or sometimes I just switch on the television, and go into that state of living, I am not really aware of what is on, it is just a moving picture. It is something to look at, and try to deaden everything.*

Int: *Deaden everything?*

Barbara: *Yes, yes. I have got a very old cat, a rescued cat and he helps actually. I sit and look at him, stroking him and sometimes that helps. I know it is silly but I do get times when I think, what is the point? Why am I living any more. I have done my bit. What else is there for me to do. And I get so frustrated.*

(Barbara, aged 66 years, middle class)

At times when Barbara felt ‘desperate’ she either expressed these feelings through crying or tries to ‘deaden’ and lessen the intensity of her emotions and memories. Barbara described this as an embodied ‘state of living’, she felt distant from her everyday surroundings as the intensity of the memories and bodily sensations were so acute within her awareness. Barbara further described a sense of loss of identity, direction and purpose in her biography, not only was Barbara now a widow but she retired a few years earlier too. It can be seen that Barbara’s emotional experience was painful, fluid and intense but there was a requirement to restrict the expression of these thoughts and feelings to her private space. This can be shown when Barbara continued by describing a visit to the theatre:

Barbara: *Like the theatre, I get the calendar. And I go through, this, this, and this, and then I think, oh god, I have got to go on my own. I went to the theatre, the Haymarket, to see a play, and it was awful. It was all right when I was in there, but the interval. I went out because I wanted to stretch my legs. You can’t sit for all that time. And everyone was together, and they were laughing and talking, and it was loud, and I just wanted to scream. But I won’t ever go in an evening again.*

(Barbara, aged 66 years, middle class)



During the interval at the theatre, the disparity between Barbara's sense of loneliness and fluid intense emotions contrasted with the social environment she was in. The sudden awareness of this results in Barbara wanting to 'scream' but her bodily expressions of her feelings are restricted due to being in a public space. Her concern that this may happen again leads Barbara to decide that she would prefer not to go into a similar social situation by herself again. This requires a continual awareness of controlling the tension between private feelings and emotions and their embodied expression in public space.

This can be further illustrated by Julian's description of his experience of becoming and being blind. Julian first articulated his emotional experience of the 'blackness':

*Julian: Soul destroying, in those days there was no support groups, no counselling, the first one went just like that, I woke up one morning, and it was black, so, just get on with it.*

*Int: How did you just get on with it?*

*Julian: Scream and shout inside, stuff like that, there was not much help in those days, get no help, just the white stick, and find your way around, just stuff like that really.*

*Int: How did you experience the blackness?*

*Julian: Ever seen Munch's painting the Scream? Like that, I've quite not got over it, the battle, with the scream, I scream inside, that painting says a lot about how I am feeling, **dead deep this isn't it, it goes on and on** (loudly) .*

(Julian, aged 55 years, working class)

Julian signified the importance of keeping his emotions 'inside', his emotional

experience is a persistent and silent ‘scream’, maintained within his bodily and spatial boundaries and hidden from the everyday world. Julian further explained why he chooses not to articulate his feelings to other people:

Int: *Are you able to explain how you feel?*

Julian: *Don't bother, it is depressing, it is depressing, doom and gloom, it depresses people, what you miss, what you can't do, what you find difficult now, they don't want to hear about that. No point, it won't make it any better, every single day I wake up, black, and you just have to try and make it better as much as you can. .What can you do? Just keep it in, inside, one day I'll go bananas, somebody will get it, I'll just go absolutely screaming mad I suppose, otherwise I will just stand there and scream, that's how it gets you sometimes.*

(Julian, aged 55 years, working class)

Due to the continual nature of his feelings, the visual and corporeal blackness of his everyday life, Julian believed that people will not want to hear his painful and difficult emotions. However, keeping these intense emotions ‘inside’ required emotional work that needed to be managed within his everyday life. For example, Julian described his feelings when he is ignored in a shop:

Julian: *When out and about sometimes people ignore me, I was at the counter the other day, and someone said can you tell him that da di da, and I said, “can't you tell him yourself, I am stood here”*

Int: *How does that make you feel?*

Julian: *Angry, really frustrated, if I'm offered help that's fine, but if people are ignorant, I just tell them straight, I have to hold back, otherwise they*



*would lock me up, the behaviour that happens to me down town, I just want to scream out, then they would take me away.*

(Julian, aged 55 years, working class)

Julian controls his feelings in public as he fears the reactions of others if he allowed himself to show his corporeal emotions by screaming out loud in public. Throughout the interview whilst voicing these intense feelings, an apparent subjective inner self that wishes to scream and shout, Julian masked these emotions by being very softly spoken except for occasional bursts of impassioned speech. The embodied constraint of his emotional experience was evident.

Janet, now a retired teacher, also described strategies to keep her emotions ‘aside’ in public space following the death of her husband a few years previously. In particular, Janet has an ambivalent feeling about her home and described the image of returning to the ‘empty’ home. Whilst her home is the space for the bodily expression of intense, private and intimate emotions, it was, at the same time, the prompt for painful memories and sensations of being alone:

*Janet: It is - it was a sort of thing, where I felt I had to be sort of doing my job the way I had always done it, as well as I had always done it, without sort of thinking, “oh I am in an awful situation, I have just lost my husband”, sort of thing. When you are at school, you don’t think of anything else, you just concentrate on what you are doing, and everything else is set aside, but when you come home the house is empty, you know, and putting the key in the lock, and knowing you are going into an empty house. That is the sort of unsettling sort of feeling and that - and then you think, “ well I won’t go home, I will go*

*out for the evening”, so you go out with friends, go out for a meal, and go to the cinema but then you have still got to come home, and I think that was the slightly unsettled sort of feeling, that I had to be doing things, almost to stop myself thinking too much, and I know I have met other people who have gone through the same sort of thing. Just an unsettled feeling, you are never quite content, and I suppose that is grief isn’t it. Or part of it.*

Int: *It is the emotional - well keeping busy sort of emotional side?*

Janet: *It is a way of keeping the emotions aside until you are on your own. Then you can sit and weep or you can throw things, I suppose I don’t get over emotional in public. I kept it until I am on my own. Occasionally I get a bit emotional with friends and family, but mostly the job was done, as it always has been done, and my social life was quite good going out with friends and so on, and they were very good. I was supported very well, and it wasn’t as if I wanted to stop thinking about Richard, or even stop thinking that he had died, it was I didn’t want to make it the centre of my life. Life still has to go on doesn’t it and you don’t want people to feel sorry for you all the time.*

(Janet, aged 61 years, middle class)

Janet described a continual sense of embodied discomfort, unsettled feelings, that she associates with her grief. Many of the women who were experiencing widowhood or divorce frequently refer to significant friends, family and social networks as a key means of support. In particular, the women shared their experiences, feelings and sensations with other women friends who had similar experiences.

At the same time, the ‘empty’ home was frequently described as the private and



intimate space in which emotions could be expressed whilst at the same time provoking the most painful memories for the participants. The intensity of these emotions resulted in participants experiencing a different sense and use of their time, with an imperative to keep busy and active. Despite these many efforts and activities to keep busy outside the home, at some point, the return to the home needed to be dealt with. There was therefore a moment of transition when the participants return to an 'empty' home, as Paul described when talking about his divorce:

Paul: *Whereas before - unless you really experience after 25 years, you know, all of a sudden you are on your own, having to cope with the emotions side of it.*

Int: *The emotional side. What does that mean? What do you mean by that?*

Paul: *Well I was frightened. At that time I was still living in the house. I moved out, I was going back to an empty house, and I didn't want to stay there. I was lucky I didn't resort to drink, because I was going down the pub nearly every night, just to get away, and be around people, but in the end I realised that it was futile, I had to pull myself together, and I used to go cycling at 11 o'clock at night, I would go for a ride on my bike for an hour and really wear myself out, and go back, and just collapse in the bed. That was the worst thing, what I hated the most. And because I finished work early, I was finishing work by 12 o'clock then, I would go back at 12.30 in the afternoon, open the door, shut the door behind me and that was it. That was me I was in the house now. And all those memories I had to get out. So in the end I thought to myself I have got to come to terms with it. I have got to be*

*strong. I have got to cope with it. I can't keep going down the pub. I have got to find my own entertainment and I mean even my - I used to love fishing and I couldn't even do that. I couldn't even fish because I kept mulling over things, but eventually like people say time heals everything. And it did and eventually I got over it and I stopped thinking about it. And you know that was it.*

(Paul, aged 58 years, working class)

This quotation is a vivid description of the transition when entering an 'empty' home at a time of loss. It can be seen within Paul's discourse that there was a tension between 'home' as a space of privacy, intimacy and sleep that is in contrast with heightened painful memories and emotions triggered by entering that space when experiencing the loss of a partner.

Many participants described the importance of keeping active and busy as a strategy to keep the expressions of painful emotions 'aside' that involved engagement with social networks, social and individual activities, sporting activities, work, projects and hobbies. These strategies were also gendered. The women predominately focused on their subjective feelings at this time and often shared their experiences and thoughts with significant others, within their perceived limitations of not being seen as a 'nuisance'. In contrast, the men's descriptions of their experiences of divorce and bereavement frequently emphasized the 'doing' of emotions in terms of keeping busy with activities and projects that were frequently undertaken alone. For example, Tony described his strategies for dealing with his painful memories and emotions:

*Tony: I built a model. That is what I done. I built a boat.*



Int: *So you focused on something?*

Tony: *Yes that is right. I built a model. And I think that is the finest thing out that is.*

Int: *To take your mind off of things?*

Tony: *Definitely yes. When Joan went I was on about three bottles of whiskey a week. I couldn't sleep otherwise.*

(Tony, aged 78 years, working class)

The men frequently referred to the importance of solitary pursuits, such as making models, work, computing, sport, gym, fishing, (motor)cycling, as a way to keep emotions, memories and thoughts aside. The pub was also cited as an ambivalent space in which the men could be social with others whilst also being alone. Many of these activities were further strategies to help with difficulties sleeping at nights, especially as the bedroom was frequently the space that provoked the most painful memories and emotions. Keeping active during the days enabled their night worlds to be more bearable. Within the men's discourses, the experiences of bereavement and divorce were often associated with an increase in alcohol intake, either at home or in the pub, in conjunction with a sense that time heals their bodies, emotions and their selves.

### Re-negotiating identity

Underlying the discourses of loss, through bereavement, retirement and as carers, described by the participants was a process of re-negotiating their sense of identity. In this way the loss was frequently experienced as a disruptive process to their sense of self, purpose and direction within their biography. In particular, the participants

questioned their identity in relation to coupledness, marital status, caring roles and work. This process of re-negotiating their identity involved a complex interplay between how the participants saw themselves, how they think they are perceived by others, and their experiences of social interactions and networks.

For example, following his divorce Gary described how he re-negotiated a narrative of self that involved a process of questioning his sense of identity, purpose and direction before he could start *'doing things that had a sense of importance for me and that I felt worthwhile'*. As Gary explained his self-image was central to this process:

*I was divorced, and didn't handle the divorce very well in terms of myself, not in terms of the process, but just in terms of how I re-adjusted to my image of myself, my feeling about myself.*

(Gary, aged 52 years, middle class)

Catharine further described the disruption to her biography as she reflected on her process of identifying with the status 'widow':

*I walked around, and I suddenly said to myself, I am a widow now. I am a widow now. And you are sort of so detached, detached from everything. You are sort of, you have done your grieving really, before he died. You grieved. Well I had grieved for four and a half years. I sat with him every day and now I am a widow.*

(Catharine, aged 83 years, middle class)

Catharine described a sense of 'detachment' that pervaded many of the emotional discourses at times of acute loss. The term 'widow' signified a significant



transformation for Catharine, not only in terms of the change of status and associated disruption to her sense of identity, but the loss of a close partnership. Many participants who were with their partner for many years discussed their partnership as a significant aspect of their identity and everyday life. For example, the taken for granted nature of being together, being a couple, was fractured when Sophie's husband died and she needed to re-negotiate a sense of self that promoted her '*own personality*':

*Well I must say, that when you are a married couple you do things together, but in a lot of cases, and in my case you are a step behind. My husband was always the main, you know, so I was always a step behind him. If you can understand what I mean. And after he went then I had to find my own personality, and make the effort myself to let people in to do things.*

(Sophie, aged 78 years, working class)

Sophie described how, following the death of her husband, that as she was no longer in a couple, she needed to find her own '*personality*'. Moreover, Sophie signified the significance of gender to relationships and coupledness, as she implied that her husband was the leader, as she '*was always a step behind*', that involved not only a process of re-negotiating her identity but learning new everyday skills, such as managing the finances and manual tasks within her household, as well as developing new social networks. The experience of losing a partner was not only a major disruption to sense of being a 'couple' but denoted a change to the participant's everyday activities and interactions:

*Fay: Or if there is something on television, and you know, you suddenly want to discuss, even having rows, you know, difference of opinion, you have got*

*nobody too. And he used to say, oh yes, you are quite right. Of course I am always bloody well right. I really miss things like that. It used to be terrible coming into the house and nobody. I used to hate that. Sometimes now you feel lonely and you don't see a soul outside. And then you say well there is other people in this position. You are not the only one and you have got to be strong. But I mean I was terrible, when you go around, and you saw people, couples together, and you feel you miss that something terrible. To have somebody with you.*

(Fay, aged 80 years, middle class)

Many of the participants who had lost a partner described a heightened sense of loneliness following the loss of a partner.

Participants who were in a couple, and had now become an informal carer of their partner due to ill-health, also re-negotiated their ambiguous identity of being 'a couple'. Shirley, for example, was a full time carer to her husband who has had a stroke, and viewing the visual image of the couple <sup>32</sup> running, triggered painful memories for her:

Shirley: *A happy couple.*

Int: *In what sort of way?*

Shirley: *Well they are obviously on a beach, or out for some sort of walk, and that is really how I pictured Doug and I would be in older life and ... (starts crying)*

Int: *Does that make it hard for you? Sorry I didn't mean to upset you.*

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<sup>32</sup> See visual image one (appendix three)



Shirley: *I am all right. I am fine. Yes I really did think you know. As I say we have always like going abroad, and things like that.*

Int: *Is that something you miss because you can't do those things.*

Shirley: *Yes.*

(Shirley, aged 58 years, working class)

For Shirley, seeing the image of the couple reminded her of her own sense of loss, an ideal future with her husband, which as a full time carer was not her everyday reality. The image projected an embodied vision of later life that was distant to many participants' everyday experiences due to limitations of financial resources, ill-health, caring roles and / or loss of a partner. Whilst in the environment of the interview the participants felt able to voice and express these complex, painful and difficult emotional experiences, the overriding belief was that these emotions were predominately to be kept hidden from the public gaze.

Many participants also described their emotions and emotional experiences associated with their retirement. There were two alternative emotional discourses associated with retirement. First, retirement was seen as a time of freedom away from the constraints of paid work that promoted a sense of enjoyment and empowerment. Second, retirement was experienced as a loss to their sense of identity and purpose with associated feelings of feeling 'low' and 'depressed' for many months. Underlying both these discourses was the notion that their sense and experience of time, identity and purpose within their biography had changed. The following quotation illustrates how Tracey has changed her everyday routine:

*Well I enjoy it - I mean we do less and less, I mean we laugh that in retirement, when I was working the house would be cleaned every week, I had a routine when I was working, but nowadays I am so busy in retirement, it doesn't get done, and I think well, it seems mad that all those years, I felt it was very important.*

(Tracey, aged 59 years)

Tracey had developed a number of new voluntary and social networks in her retirement that promoted a sense of purpose and identity. The priorities in the use of Tracey's time also changed and her feeling about her retirement was predominately one of enjoyment and freedom. After many years in a job that Gordon did not enjoy, he also discovered a sense of freedom when he retired:

*I realised that there were doors, intercommunicating doors all over the place. In ordinary life you just walk on by. With this, you stick your neck out, and you can more or less do anything, it empowers.*

(Gordon, aged 68 years)

Gordon had started taking educational courses, voluntary work and developed new interests. These experiences had opened up the possibility of many more opportunities than Gordon had previously felt possible.

In contrast, a number of participants experienced a sense of loss and feelings of being low and '*depressed*' following their retirement. In particular, these participants described a questioning of their identity, loss of social networks associated with work, and loss of a sense of purpose in their life. For example, Patrick a retired



computer expert <sup>33</sup> described how he continued to feel ‘*useless*’ for whilst he had activities to fill up his week he always felt he could do more. In particular, he missed the discipline, status and sense of purpose that work gave him.

Peggy instead described her first few months of retirement in which she emphasised the loss of social networks and everyday interactions that she had built up over many years:

*At first it was like a holiday. I had lots to do. I was going to decorate, and I decorated all upstairs, and all that sort of thing, and I supposed about eighteen months into retirement, I suddenly got very depressed, and somebody reminded me about the bereavement course I had been on. They said you have forgotten that now you are going through the grieving process. Because you have been busy and suddenly miss that extended family because I have worked at my company for 26 years. After being there all those years, and the girls that I worked with, had also worked there a long time. So we had watched our children grow up and so it was an extended family more than anything, and suddenly it hits you that you hadn't got that extended family, that you shared your life experiences with really, or if you had a little moan about your husband or your children or anything. We supported each other and it was great and suddenly that was gone ... And I think a lot of people go through this and they don't realise it is grief. They feel it is depression and not a grief for - not necessarily the actual job but the people they worked with. Because you are with them nearly eight hours a day which is longer than you are with*

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<sup>33</sup> Aged 64 years, middle class.

*your own husband or partner or whatever. It is a long time to be with people, and you bounce off each other, and suddenly that holiday period had gone. Suddenly very much alone. Very much alone.*

(Peggy, aged 64 years, working class)

Peggy described how after six months she started to feel better and readjusted to a new routine and developed a network of social activities. Underlying many participants' discourses was the imperative that the key to having an enjoyable retirement was how well time was utilised and to what extent the participants found a sense of purpose in their use of time. A number of participants articulated the importance of having a balance between keeping busy and active with ensuring that sufficient time and space was available for moments of privacy. For other participants who were retired for reasons of medical ill-health (three of the men) and other participants with significant caring roles and / or limited resources, in particular the participants on income support, there was frequently a more ambivalent feeling about their retirement. Retirement for these participants was a balance between the perceived opportunities of no longer being limited by the constraints of family responsibilities and / or paid work, and significant financial, mobility and time limitations imposed on their lifestyle choices.

#### Caring, (ill) health and emotions

At times the emotional experiences in everyday life further related to the extent that some participants felt that they had control of different situations in their everyday life. Living with ill-health, depression, as carers for significant others, and during bereavement, signified periods of uncertainty and flux within their biographies. It was



often a sense of being ‘*out of control*’ that some participants articulated when experiencing painful and difficult emotions.

A few participants had experienced difficult and painful times during their lives, for example, periods of ‘depression’, emotional distress and alcohol addiction, that influenced their emotional experiences in the present. Moreover, participants who had been in emotional therapy had appeared to construct a more coherent and therapeutic sense of their emotional self. These participants had a tendency to be more accepting and reflective of their own and others emotions in everyday life:

*A more difficult one to deal with, is if you are depressed, because depression is a terrible thing, and you can't get out of it yourself. People say to people who are depressed, you can get yourself out of this, you know, and pull yourself together, but it is not like that.*

(Derek, aged 67 years, middle class)

Of particular note, the majority of participants who had significant caring roles for others, such as their partners and / or parents, described significant periods of depression and feeling low. The reasons cited for these emotions were inability to develop social networks, uncertainty about their present situation and a sense of responsibility for the other person that needed to be mediated in relation to their personal and social needs.

Derek lived a distance from his mother who had dementia but he felt a continual sense of responsibility to his mother and his work and family, both situated in different localities. His mother would regularly telephone Derek in the evening, and

in the following quotation, Derek described his bodily emotional reaction to the trigger of phone ringing:

*Derek: Yes it tended to be one of those things that hits you, when the phone rings, and it might knock me out until the evening, then I can't concentrate, I can't watch the television, I will be fretting. I might not sleep, but then the next day the pressure of one of my challenges gets me up and going again.*

(Derek, aged 67 years, middle class)

Derek described bodily problems associated with his emotional distress that included irritable bowel syndrome, pain in the abdomen and insomnia. Derek at one point said that the only symptoms of his emotional distress were bodily. Derek further related these bodily symptoms to feelings of being '*out of control*' that he had experienced earlier in his life during a prolonged period of depression. And it was the sense of responsibility, and his inability to change (control) the situation in his private world, that resulted in symptoms of fretting, losing concentration and having difficulties sleeping. This contrasted to a sense of purpose and focus derived from being at work in his public world. Being worried about dilemmas in everyday life often led to sleep difficulties for some of the participants, in particular, concerns about family and social relationships.

Shirley, a full time carer for her husband, also articulated feelings of depression. When Shirley had been diagnosed with 'depression' she had felt reluctant to identify with this label and she still continued to keep her painful and depressive feelings hidden from the public world. In particular, full time carers have difficulties receiving care and support for themselves, and very limited opportunities to voice their own



emotional experiences. For Shirley, she finds it difficult to explain how she feels, and frequently repeats '*I can't put my finger on it*':

Shirley: *I don't know really. I don't really think about it that much. I just get on with it. A bit boring at times, you know, as I say I miss conversation. But then I am saying that, but I can't talk to anybody anyway. But I suppose it is a case of just, you know, it is your life so you have got to get on with it haven't you. It is no good sitting grieving about it.*

Int: *You said you had been a bit low recently.*

Shirley: *Er yes. I don't know. I can't really put my finger on it. I just get like that sometimes, and then I just sort of give myself a shaking, and get out of it.*

Int: *Different in what way?*

Shirley: *Calmer really. Yes. She said it is unbelievable how much calmer you are you know. Well I don't know really. It is hard to put my finger on it, because really, I wouldn't accept that I was depressed. I didn't even think that I was depressed. The doctor told me I was.*

Int: *And what did you think then?*

Shirley: *I didn't think anything. I just thought the situation got me down now and again, and I just lost it. You know, but then I would pick myself up again, which I did do. But I suppose each time I dropped down I got more and more down and just didn't realise it.*

(Shirley, aged 58 years, working class)

Within this quotation it can be seen how difficult feelings are to describe. Shirley was reluctant to accept a diagnosis of depression, as she saw this as a sign of

weakness, and therefore decided to hide her feelings away. At the same time the tendency to ‘shut out’ everything is a part of depression as described by Joan, who had previously been a carer for her husband, who was now living in a nursing home:

Joan: *You want to shut everything out. I couldn't see any future. I could just see, him and his illness, and I wanted to shut everyone out. It was a horrible sort of life. I was up in the night with him three or four times and he was like a child.*

Int: *So you were feeling depressed at that time?*

Joan: *Yes. Alone and depressed.*

(Julia, aged 60 years, middle class)

The inability to engage with social networks, acute feelings of loneliness, limited financial resources and a continual sense of caring responsibilities led to the feelings of ‘depression’ for these participants. It is therefore interesting to note that the most effective strategies of support that they cited were direct payments, daycare and access to alternative therapies. It was the opportunity to have time, space and engage in social networks that promoted their emotional well-being significantly.

### Concluding comments

Embodied and embedded within the biographical interviews were descriptions of emotions and emotional experiences both in the context of the participant’s everyday lives and at critical moments, in particular, significant times of change and loss. The expressions and experiences of emotions were articulated in the context of their everyday lives in relation to their social interactions, coupledness, their characteristics of self and their embodied sensations and strategies used to avoid negative emotions,



such as, feeling low and loneliness. The participants also described their heightened emotions at critical moments, such as, retirement, as carers for significant others, bereavement, divorce and illness. Emotions were certainly central to their everyday lives.

Throughout these emotional discourses a number of underlying themes about their lived emotional experiences emerged. First, participants experienced intense and fluid emotions that needed to be managed within public and private space and bodily boundaries. In particular, there was a continual tension between inner (private) subjective feelings and *experiences* of emotions and the outer (public) bodily and spatial *expression* of these emotions. Second, the experience and expression of emotions and the different strategies to deal with emotions was gendered between men and women in later life. Third, gender, chronological age and social class were significant to the different types of social networks and resources that the participants could draw upon as a means to gain support when experiencing complex and painful emotions. These different resources and social networks were moreover significant to the ability of participants to successfully negotiate these painful emotions. Fourth, being active was cited as an important strategy to maintain a good sense of well-being. The following chapter will now further explore the participant's own ideas about health, risk and active ageing in everyday life.

## 5

### **Embodied Vulnerabilities: Health, Risk and ‘Active’ Ageing**

*Every little trifle, for some reason, does seem incalculably important today, and when you say of a thing that “nothing hangs on it” it sounds like blasphemy. There’s never any knowing – how am I to put it? – which of our actions, which of our idlenesses won’t have things hanging on it for ever*

(E.M.Forster, *Where Angels Fear to Tread*)

The focus of this chapter is to explore the participants’ own ideas about ‘health’, health-related lifestyles and risk in everyday life. It has been through an exploration and questioning of the habitual and everyday nature of daily living that I have engaged with the perspectives, concerns and meanings of people in later life about their health, lifestyles and sense of ‘risk’ and embodied vulnerability. The daily lives described by the participants were frequently associated with ideas about health, vulnerability and the body. At the same time, perceptions of health were interwoven with discourses about risk, vulnerability and the ageing body.

It is important to emphasise that the data presented within this chapter all relate to the discourses, meanings and interpretations that the participants described in relation to health, risk and the *body*. The ageing body (chapter 3) and embodied emotions (chapter 4) were also central themes within the everyday lives of the participants. These embodied distinctions are therefore solely analytical in terms of presentation of



data and themes: in the everyday lives of the participants different meanings and perspectives were closely intertwined in complex and, at times, contradictory ways.

The data presented in this chapter emerged both in the context of the biographical interviews and as part of the process of photo-elicitation. Whilst all the participants were asked specific questions about their health and health-related lifestyles towards the end of the interview, these themes emerged spontaneously throughout the interviews unprompted by me as a researcher. This suggests that health, health-related lifestyles and the body were significant within the everyday lives of the participants. This chapter will now illuminate the complex interplay between health, risk and lifestyles within the everyday lives of the participants.

### **Health, Risk and Embodied Vulnerabilities**

All of the respondents were aware of health promotion messages that advocated changes to health related behaviour in relation to identified risk factors, such as, diet, exercise and smoking. When situated in the everyday worlds of the participant's meanings, interpretations and ideas about health promotion discourses were complex and involved intricate interconnections between expert discourses of risk and their own localised logics. Within the context of descriptions about everyday life the participants described ideas, meanings and perceptions around risk, health and the body. In particular, the participants frequently associated ideas about health and risk with their own bodily experiences, for example, bodily changes, body weight and perceived vulnerabilities of the body. Underlying these discourses was a sense of vulnerability associated with old age. Awareness of the body was therefore

significant when engaging with meanings about health, discourses of health risk and making choices within everyday life.

### Meanings of health

Health was predominately taken for granted until participants experienced ill-health and / or other changes associated with growing older, such as, aches and pains, increased body weight, and ‘doing’ less:

*Well I can't think of being any other way.*

(Ada, aged 96 years, working class)

*I suppose when you think of health you think back to days when you were young and very active*

(Sid, aged 80 years, middle class)

When participants experienced ill-health, and / or bodily constraints that limited their participation in everyday and social activities there was a heightened awareness of and significance to health in everyday life:

*Well it is everything isn't it. I mean being healthy.*

(Fay, aged 80 years, middle class)

Health was often described as a sense of ‘being’ and the body was frequently central to discourses about health and (well) being:

*Being comfortable in the body and being able to do what you want to do*

(Gordon, aged 68 years, middle class)

The sense of being at ease with the body signified that health was often recognized by its absence. Indicators of being healthy included not being ill, being without pain, having ‘glowing’ skin and eyes, and continuing with everyday activities:



*Health means not being ill. Not being ill. Health means a feeling of well being. Everything working nicely. No pain. Health means being able to walk places and not be out of breath. It means glowing eyes and skin.*

(Sarah, aged 55 years, working class)

Meanings of health therefore involved complex interconnections between a sense of well-being, functionality of the body and the (outer) appearance of a 'healthy' body. Boundaries of the body were key parameters against which the participants predominately evaluated their own health. For example, some participants interconnected health and body weight:

*Bill: A very difficult question. I mean we both realize, that we have got quite overweight. We are very conscious of that.*

*Tracey: It's all those crisps and stuff.*

(Bill, aged 60 years and Tracey, aged 59 years, middle class)

Other aspects of bodily boundaries included perceptions of level of fitness, mobility and independence:

*To keep fit, and to keep mobile, really. You know, not to continually be at the doctors, or you know, and as I say, to maintain your independence really*

(Ivy, aged 71 years, middle class)

Health, well-being and the ability to function in everyday life further reflected a sense of self and identity:

*Health. I just suppose for me it just means being able to do things. What I want to do within my self. Like if I wanted to, and I am able to do, because I*

*am fairly healthy. If I want to do a lot of walking I can do that. It is keeping my body in as good a state as possible, by whatever means that I can use.*

(Anna, aged 67 years, middle class)

Discourses associated with functionality and everyday life were not only about bodily health as some participants distinguished between their physical and mental / emotional health. This was especially evident amongst the participants who had experienced depressive episodes within their biographies. For example, whilst Barbara considered herself physically healthy, despite experiencing a number of chronic illnesses, she described her mental health as ‘unhealthy’:

*Barbara: Well I am able to get about. I am not always ill. I am not sure it doesn't include my mental health, because sometimes I think I am mentally quite unhealthy.*

*Int: What do you mean by that?*

*Barbara: Well because I get very morbid and ...*

*Int: Is that just recently or has that always been part of your life?*

*Barbara: I have always been a bit of a depressive, and I suppose that is part of it. And losing my husband has made things a little bit worse now.*

(Barbara, aged 66 years, middle class)

Due to depressive illnesses within their biographies some of the participants highlighted the importance of their emotional health. This distinction was often articulated as a distinction between a healthy mind and a healthy body. Physical and emotional functionality in everyday life was therefore also central to the discourses about health.



When asked about meanings about health participants also articulated an increasing importance of ‘doing’ health. This included taking care of own health; maintaining fitness, mobility and independence; and avoiding ill-health. In particular, as the participants grew older there was a heightened sense of importance of a need to take more care of body and self:

Catharine: *Health. Well it means, what do you mean what health means to me? Keeping healthy, keeping well, taking care of yourself.*

Int: *In what sort of way?*

Catharine: *Well not overdoing things, not too much alcohol. Not too many. God. You had better scrub. Cigarettes. Not too much alcohol. Eat sensible food. Take a fair amount of exercise.*

(Catharine, aged 83 years, middle class)

*Just looking after yourself. This is why I packed up smoking. It is time to look after yourself.*

(Harry, aged 67 years, working class)

Participants linked their perceptions and meanings of health to the everyday praxis of health maintenance that predominately drew upon risk discourses associated with health promotion, such as, smoking, diet, exercise, and alcohol consumption. Some participants further interconnected ideas of health and a healthy lifestyle with a sense of personal responsibility:

*I think if you have a healthy lifestyle, take exercise and eat well, and look after yourself, I think it is important to take responsibility for your own health.*

(Nicole, aged 50 years, working class)

In this context, the participant's meanings of health were often inextricably interconnected with public health messages about active ageing. This further suggests that as the participants grew older that the taken for granted nature of health lessened and was increasingly replaced with the idea that health was to be actively worked at and achieved. The link between the meanings of health and everyday practices suggested that there is an underlying sense of embodied vulnerability about health. The maintenance of health furthermore increasingly required activity and scrutiny as people grow older.

#### Perceptions of risk, health and the body

The body was also central to many participant's accounts of health and risk. Care of the body involved monitoring everyday practices such as, diet, exercise, and smoking and/or alcohol levels. In this context, the body was portrayed as an entity that functioned at its optimum with proper care, fuel and stimulation:

*But I think if you look after your body really. I think that is half the battle isn't. I mean, keeping it fit, and that, and eating the right foods.*

(Tony, aged 78 years, working class)

In particular, the objective of everyday health practices was to ward off any negative symptoms associated with old age, such as, ill-health, increased body weight and memory loss. Many participants had, for example, become increasingly aware that current health practices may have consequences for their health in the future:

*I think you have a responsibility to look after your body. I don't smoke. I gave that up the same time as I gave up drinking. I didn't miss I, once I went*



*through that, and did it. I don't want to end up with some illness in later life, that I could have avoided by being sensible.*

(Theresa, aged 68 years, middle class)

Participants further articulated a distinction between maintaining an active body and an active mind. For many participants there was an imperative to keep active:

*I think, as long as you can move around, and get along. Your mind, I think that is a lot. To keep active, that is the main thing.*

(Fay, aged 80 years, middle class)

The mind as well as the body therefore required care, activity and vigilance in later life: associated with accounts of health risks was therefore an increased sense of embodied vulnerability

Experiences of the body often led to a heightened awareness of potential health risks. Participants pointed to bodily symptoms that led to changes in their health related behaviours. For example, Emily described how a sudden chest pain whilst walking up a hill increased her awareness about health risks and smoking:

*And yes, I quit smoking, and then, I was walking up the hill one day, it must have been two years ago now, and it was just as though somebody hit the back of my car, like that, with a sledge hammer, and I thought, ah, I know what that is.*

(Emily, aged 71 years, working class)

Bodily experiences intruded on participant's everyday lives and the taken for granted nature of health and everyday health practices was questioned:

*Well I was getting pains in me chest and me heart rate was going up and*

*when I was getting up in a morning it was getting quite difficult to swallow.*

*So I said that is it I am giving up. And that was it. I gave up.*

(Harry, 69 years, working class)

It was often bodily symptoms that led to changes in health related lifestyles associated with smoking, diet and exercise. Personal and bodily experiences were therefore central to increased awareness of risks that may affect current and future health.

Participants also described episodes in their everyday life associated with losses in memory. Lapses in memory were frequently linked to growing older:

*Angela: No, that is one of the things, that as you get older, we all do it, we have friends who are getting on, who all do it, we start things, and then you can't think of the word that you want.*

*Int: Does it worry you at all?*

*Angela: It is not an illness as such, it is just part of the general ageing process.*

*Sid: That is when you are doing the crossword, and you have got a word in the back of your mind, and you can't fetch it forward. It is there, what is it? And then, you start saying "well it is yellow, and it is long and it curves a bit or something", and it ends up you are talking about a banana or something.*

*Angela: I am usually thinking, "I can't think of the word", I know it begins with a P, or something to begin with a C.*

(Angela, aged 78 years and Sid, aged 80 years, middle class)

Everyday lapses in memory, such as, forgetting names, going into a room and not



knowing the reason, and difficulties recalling words, were discussed amongst friends and relatives of a similar chronological age, and it was generally agreed that it was a natural (and expected) aspect of growing older. Whilst age and ageing was the explanation for everyday forgetfulness the participants signified the importance of being active and consciously including everyday activities that enhanced memory skills:

*I think it is a case of, if you don't use it you lose it. It is the same with the brain as it is with the body.*

(Anna, 67 years, middle class)

Activities identified to enhance an active 'mind' included engaging with social networks, going out every day, doing projects requiring focus and concentration, voluntary and / or paid work, keeping up-to-date with current affairs, reading and participating in quizzes and crosswords. These activities were situated in the context of everyday practices and activities: being active did however require a level of increased vigilance during daily schedules. Everyday forgetfulness was moreover directly linked to growing older.

Other health risks were described as less visible, such as, high blood pressure and cholesterol levels, and were predominately detected through routine health screenings. These conditions were often diagnosed without the participants experiencing any bodily symptoms. This can be illustrated within Marilyn's description of her visit to her doctor:

*In general, the doctor will say, oh, you have got high blood, and take the blood pressure, and see how bad it is. Oh no, that is not very good, so we will*

*give you some more tablets. I don't actually want to take tablets, and I wish I didn't have to take tablets. I feel fine I have no symptoms.*

(Marilyn, aged 71 years, middle class)

Within this quotation Marilyn's perceptions of health and health risks were mediated via the perspectives of a medical doctor. The absence of discernible bodily symptoms resulted in Marilyn having difficulty making sense of her diagnosis and in consequence questioned the need for the diagnosis and medication. Without visible symptoms some participants described taking medication in relation to caution and safety rather than the alleviation of any symptoms:

*She has just put me on a tablet for cholesterol, but other than that, you know, it is very borderline. She has just put me on a tablet, just to be on the safe side.*

(Clive, aged 73 years, middle class)

The invisibility of symptoms highlighted the nature of hidden and unknown risks that rendered the body vulnerable. As the need for medication was predominately based on a relationship of trust (cf. Giddens, 1991, 1992) with health practitioners, and not based on their own bodily experiences, participants tended to draw upon abstract discourses of health risk to make sense of everyday experiences of risk. The body and bodily boundaries were therefore central to the participant's perceptions of health risks in which an awareness of bodily experiences enabled participants to both make sense of and make decisions about perceptions of health risks and everyday lifestyles.



### Embodied vulnerabilities and everyday life

A sense of embodied vulnerability further influenced the daily schedules of the participants. This was due to previous bodily experiences and / or increased perceptions of risks associated with the body, such as, falls and mobility difficulties. Concerns about everyday safety and security were therefore increasingly significant. Perceptions of bodily vulnerabilities in everyday life were related to chronological age, gender and living arrangements.

Perceptions of everyday bodily risks were linked to living arrangements; in particular, living alone was seen as a high risk situation as no immediate help and support would be available if needed. There were, for example, heightened concerns about certain daily activities, such as, bathing and the risk of falling. Some of the older participants aged 80 years and over described difficulties with bathing:

*Ada: I got in the bath, and couldn't get out.*

*Int: What did you do?*

*Ada: Well, I had to struggle in the end to get out.*

*Int: Did that worry you?*

*Ada: I am not going to bath again, until I get the hand grips. I have got them one side, but not the other, and the walk in baths are heaps better. But I suppose, I can't get one of those.*

(Ada, aged 96 years, working class)

Mobility difficulties, pain and perceptions of the risk of falling heightened increased concerns about safety when bathing. Perceptions of bodily risks led to changes in everyday practices with some participants choosing not to take a bath and / or via the

installation of additional mobility aids, such as hand grips:

*And I don't use the bath, because I can get into the bath, I can get out of the bath, but if I am horizontal, I have trouble with my back, so when you are living alone, and you try to get the towel, when you are in the bath, you are apt to slip. I get very rigid. I think because, you know, I think you are better to have a shower.*

(Fay, aged 80 years, middle class)

Concerns about safety, pain and limited mobility resulted in Fay's body becoming 'rigid' in the bath: perceptions of heightened vulnerabilities and risks were therefore lived through the body. Participants who lived alone also talked about increased concerns about falling:

*I thought, good grief, if I fell here out in the garden, my neighbours are away. My daughter might be too busy, or she wouldn't know where I was. Because sometimes, she will go two or three days without contact with me. And I thought, I could be out here all night, if I couldn't move. I mean, you don't think about things like that, a lot of the time.*

(Barbara, aged 66 years, middle class)

Concerns about safety and security were related to the social networks of the participants, in particular, perceptions about the amount and timeliness of any help and support available. Interconnections between the ageing body, living alone and restricted access to social networks led to an increased sense of embodied vulnerabilities within the localized and everyday social worlds of the participants.

Perceptions of risks in a shared household were frequently intertwined with one



other. Angela and Sid, for example, described concerns about Sid continuing to use a bath:

*Angela: That is a minor concern. He hates change in any shape or form. I love change. And it takes me a long time to achieve anything I want. Well, because he had his funny turn, we decided it would be a lot safer if we had a shower, instead of a bath, because if he was in the shower, I could do something to assist him. If he is in the bath, there is nothing. He is much too heavy. There would be nothing I could do, and by the time I had phoned round, he probably would have sunk under water.*

*Sid: You could pull the plug out.*

(Angela, aged 78 years and Sid, aged 80 years, middle class)

Living together involved interconnections of risk discourses as couple's accounts were inextricably linked in relation to the temporal and spatial structuring of daily living (cf. Twigg, 2006). Some participants also focused on parts of their body that required special care and attention. For example, Julian described the importance of taking care of his hands that were now a key sensory resource to his everyday practices since he became blind:

*Yes, there's lots of little worries, about damaging my hands, so I couldn't paint, caring for the hands, is the most important thing. Physically try not to injure them, by smashing into a wall, or whatever, just make sure I don't damage them.*

(Julian, aged 55 years, working class)

The structure of daily living within Julian's household was centred on potential risks due to his loss of sight, such as, the arrangement of furniture and the organization of

domestic tasks. Heightened senses of embodied vulnerabilities were thereby a significant aspect of the structuring of daily living, in particular, when participants had previously experienced difficult situations and / or injuries to the body.

Perceptions of everyday risk were further linked to gender. Sid in the quotation above, for example, was reluctant to accept bodily vulnerabilities that led to changes in the structuring of the household and denoted a level of dependency on his wife Angela. Alternatively the man often focused attention on the physical vulnerabilities of the woman:

*This is somewhere where we do have confrontation, because she will get a chair, and take it up there, and get something out this high cupboard, right, which I can reach quite easily, and that annoys me. The other thing, she doesn't actually do now, on pain of death, and actually gets the loft ladder down, and goes up in the loft, when I am not in the house. She is not allowed. That is a 'no no' most strictly. Right, because if she is going to fall, I want to be here to watch it! But if she falls down there, she could be laying there for hours, if I am in the garden.*

(Peter, aged 66 years, middle class)

Within the household there were rules about risk which were predominately based on the perceptions of the embodied vulnerabilities of the members and linked to perceptions of masculine and feminine spaces and tasks within the home. In particular, situations of risk focused on one aspect of a member's bodily experiences and / or daily schedules, such as bathing and / or household chores and perceptions of risk were based on personal experiences, such as previous falls and / or mobility



difficulties: the women were moreover frequently constructed as vulnerable and requiring additional everyday scrutiny and care. The integrity of the ageing body was constructed as an entity at perpetual risk, a body that could no longer be relied upon. Ideas of ageing bodies, risk and gender therefore interconnected to influence the use and meaning of temporal and spatial dimensions of the home (cf. Mowl *et al.*, 1999).

### Weighty bodies, gender and risk

There were complex interconnections between health, ageing and the body within the participant's accounts of weighty bodies. It was generally accepted that increased body weight was associated with growing older (see chapter 3 for a full account). At the same time increased body weight was inextricably linked to risk discourses associated with health, in particular, diet and exercise. The participants own perceptions and meanings surrounding weighty bodies were therefore interwoven with expert discourses of health risks.

Whilst both men and women signified concerns about increased body weight, and / or avoiding weight gain, there were significant gender differences within these discourses. The men frequently associated increased body weight to concerns about their health and bodily functionality. This can be illustrated from Simon's response to the question about whether he had concerns about his health:

Simon: *Other than, well I already have blood pressure, and probably being clinically overweight, and possibly obese.*

Int: *And what do you think of that? Is that something that you think about?*

Simon: *It would be nice to be able to lose weight, and get down to, what is*

*accepted externally as a reasonable weight, but I enjoy food too much probably. I don't think I eat excessively, so I think providing, I am not doing things in, what I consider to be excessive, then I am quite happy, to stick with what I have got.*

(Simon, aged 58 years, middle class)

Simon directly related health to his body weight, described within clinical categories, and therefore evaluated his own body weight in relation to perceived 'norms' within health promotion discourses. Simon viewed these assessments as 'external' and distanced expert discourses from his own localised ideas about his diet and weight. Simon's explanation for body weight was that he enjoyed his food, a pleasure that he was reluctant to give up, and the men often linked their body weight to their diet. There were however discrepancies amongst the male participants about the extent to which their diet contributed to their weight gain. Some of the men related their weight gain to using less energy, 'doing' less, growing older, and biographical changes, such as retirement:

*I was able to burn off calories. I know that I suffered a weight problem. And therefore, it was something of a surprise, when it caught up with me. I thought I could eat whatever I want, as much as I want, and I thought, oh this is great.*

(Gordon, aged 68 years, middle class)

Gaining weight was often described as a gradual process that was not immediately discernible. Changes in bodily weight resulted in some of the men making fundamental changes to their lifestyles. For example, Pete explains his reasons for starting an exercise class:

*Two years April. Two years April. I couldn't get into my clothes. I weighed 23*



*stone. Well I was putting two and two together, all the heart, the weight, you know. I looked at my life.*

(Pete, aged 58 years, working class)

A combination of health risks, increased weight gain and being unable to wear the same clothes, also led a number of the men to make significant changes to their diet:

*You have to buy stuff, that helps you slim down. You have to change what you put on your bread, and may be consider having nothing on your bread. You have to consider how often you eat during the day. You don't have all these snacks, and things, that people take for granted. For instance I will have that bag of crisps. I will have that snack bar, and have a bar of chocolate, and just eat it all in one go. I don't actually have any of them at all now.*

(Gordon, aged 68 years, middle class)

Changes to dietary practices required a more disciplined and conscious approach within their everyday life and monitoring of food intake became a daily practice for some participants:

*Going back to the diet, I do try and monitor what I eat. I don't have a lot of potatoes. As I say I monitor what I eat and I keep it down to what I consider to be reasonable portions. But the scales don't tell me that I am having any major effect.*

(James, aged 67 years, middle class)

This was especially the case when the participants had an underlying health condition that was attributed to increased weight gain, such as, high blood pressure,

heart conditions and diabetes. At the same time maintaining this level of discipline within everyday life was difficult and, at times, the participants described eating food for enjoyment and a sense of ‘release’ (cf. Crawford, 1984):

*Well it does, because you are constantly having it at the back of your mind.*

*There are occasions, when you really fancy something, and you enjoy it. But at the back of your mind, you are thinking to yourself, I really shouldn't be doing this.*

(James, aged 67 years, middle class)

However, despite the immediacy of pleasure of eating food for enjoyment there was a continual intrusion in the ‘back of the mind’ about the future effects of this behaviour. Risk discourses associated with health, in particular, diet and exercise, therefore intruded into the intricacies of daily living for some participants.

The women also signified the importance of bodily functionality and health in relation to their own body weight. However, in contrast to the men, the women predominately focussed on their subjective feelings about their body weight, especially in relation to their bodily appearance and comfort. For example, Ivy was waiting for a hip replacement and, on recommendation from the surgeons, she was trying to lose weight:

*I am trying to lose some weight. I have managed to lose two stone four pound since Christmas. Because of my hip. They recommend that, they say, if you have a weight problem, try and lose some weight. Well I am small boned, and I was a bit weighty, for my bone structure. So I wanted to try, and I have done it, and I am quite pleased with myself. Because I was only tiny. When I*



*married I was only seven stone, and I went up to twelve, so I have got down now to nine ten. So I am quite happy.*

(Ivy, aged 71 years, middle class)

Ivy emphasized the significance of promoting her bodily functionality: the objective of losing weight was to increase her mobility and limit the pain from her hip. Her subjective feelings about her loss of weight were however about being ‘happy’. The women frequently related their body weight to perceptions of (un)happiness. For some women, the search to feel ‘happy’ about their body required an active, disciplined and conscious effort in terms of their daily schedules and lifestyles:

*I am quite conscious of what I eat. I try not to buy ready cooked things, you know, occasionally you do. If you are busy coming in and out, and if you are coming in from work, or college or something, then sometimes you have to do these things, they are full of salt and fat, and they are expensive, and they are not that healthy for you, though with some of them, you get healthy eating options. I like to have the time to cook, especially in the evening, if I am sitting round, and my husband is sat next to me with two cakes, like he had last night, and chocolate biscuits. Well I might be a devil, and have a Rich Tea biscuit with my cocoa, but that is it. Very occasionally, I might with the cake, or whatever he is eating. It is hard, but I know I am just going to put the weight on. And then I will be unhappy, if I put weight on.*

(Nicole, aged 50 years, working class)

Within Nicole's discourse there was a continual monitoring of her food intake and the amount of exercise taken each day: the governing of the self and a disciplined body were evident. Nicole's everyday practices and lifestyle choices were permeated by risk discourses associated with health and health promotion. However, her objective was not solely about the promotion of her health but enhancing her sense of happiness about her body and self. For Nicole, her body was a project that conveyed her identity as a disciplined and active self. For many of the women their bodily weight was an important aspect of their identity and appearance.

However, maintaining a perceived 'ideal' required work and discipline that either led to a sense of disappointment, with a wish to be 'slimmer', and / or a process of negotiating compromise within the women's everyday lives:

*How I want me to be, like I would like, to be half a stone lighter. I don't know whether that is the recognized amount, but I think you can feel if you are overweight. When people look at me and, say well you are tall, and so it doesn't matter. It does. It does. Because I can feel that I am over the weight, that I want to be. I can't bend over as well as I used to be able to. Well in any case I can't bend over as well as I want to be able to, and I get a bit impatient with myself then, but there is no way that I am going to stop eating chocolate, because it is bad for me and it makes you put on weight, so I have to again compromise a little bit here. I do a lot of compromising, you can tell.*

(Anna, aged 67 years, middle class)

The continual discipline required reaching a body weight goal in relation to the perceptions of bodily appearance and comfort was difficult for the women to



consistently maintain. To counterbalance the discipline and continual monitoring of daily practices the significance of health as 'release' (cf. Crawford, 1984) was promoted by the women. Negotiating health, risk and identity in relation to body weight was thereby complex, gendered and at times, contradictory.

### **Health, Lifestyles and Everyday Life: facilitators and constraints**

Participants own localised knowledges and ideas about risk interweaved, and at times contradicted, with expert discourses on health and risk. There were moreover a number of factors that influenced the choices that participants made in relation to health related lifestyles, which included, gender, chronological age, living arrangements, health as 'release' (cf. Crawford, 1984), and daily habitual practices. When situated in the context of the daily lives of participants, there were therefore facilitators and constraints to engaging with (recommended) health practices.

Towards the end of the biographical interview all of the participants were asked the question 'what do you do for the sake of your health?' The lifestyle changes identified by the participants were as follows: stopping smoking, dietary changes (that included less salt, low calorie, low fat, less additives, more fruit and vegetables, less sugar), taking more exercise (that included yoga, keep fit, walking and cycling), drinking more water, engaging with alternative therapies, taking daily vitamin supplements, drinking less alcohol, taking a daily aspirin, and no lifestyle changes at all. The participants were therefore aware of health promotion messages that advocated changes to health related behaviour in relation to identified risk factors. Participants acquired ideas and knowledge about health and health promotion from

the media, health and medical practitioners, and within the context of their everyday lives. The majority of participants had engaged with risk discourses of health given they had made (or attempted to make) specific changes to their daily practices.

However, there were a number of identifiable facilitators and constraints to the process of changing health related lifestyles within the discourses of the participants. These included: (1) habitual practices of everyday life; (2) gender, class and care; (3) age, ageing and the lifecourse; (4) health as 'release' (cf. Crawford, 1984), and (5) fate, luck and chance.

#### (1) Habitual practices of everyday life

Participants described how many aspects of their everyday practices were routinised and habitual. These practices did not require conscious deliberation and predominantly were not thought about at all. Certain practices were therefore interwoven into the participant's daily lives. Changing lifestyles was therefore complex and difficult as many rules and practices were integral to the participant's daily lives. When participant's described changes to their lifestyle, such as diet, smoking and exercise, it was predominately in the context of their daily practices. For example, Bill discussed how he had made changes to his diet:

Bill: *And it only took 20 minutes, to cut up the vegetables, and make it. And I mean, I could have cooked egg and chips.*

Int: *Is that what you would have eaten?*

Bill : *Well, for example, you know, I could have cooked him (his son) egg and chips, and I would have taken the same amount of time. I probably enjoyed*



*the soup more. So it is that kind of thing, that we are doing rather than you know.*

(Bill, aged 60 years, middle class)

Change was facilitated when it fitted into everyday routines and temporal structures of daily living. The habitual nature of certain practices however was disrupted in relation to significant biographical events, such as widowhood and retirement:

*When I was at work, I used to drink as many as, 25-30 cups of coffee a day. I would drink a lot a day. I have never noticed it, I have noticed, but you don't now, unless you do something different. But it has never worried me you know. I have never worried, about not being able to get to sleep. But if you don't notice something you, are not going to bother about it. I tell you. No matter how many experts say it is bad for you.*

(Patrick, aged 64 years, middle class)

Drinking large volumes of coffee was an integral aspect of Patrick's working life that he only became aware of following his retirement. The everyday logic of his practices was questioned due to a radical change in routine and thereby opened up for critical reflection. For whilst practices, such as smoking and drinking high levels of caffeine, can be viewed as high risk activities in health promotion discourses, when situated within the social worlds of the participants these practices were constructed as everyday and unproblematic. Patrick made his decision about everyday practices based on his own experience; he did not discern any ill-effects from drinking large volumes of coffee and thereby discarded the advice of experts.

The habitual nature of everyday life was especially evident when participants

facilitated changes to their customs and practices. The following extract is Harry's description of stopping smoking:

*But at various times of the day, after a meal, you want a cigarette now, and at various times of the day. This is what I found so hard. The first day wasn't too bad, the second day every minute of the day, I was thinking about having a cigarette, then as the time from when you gave up past, and it gets further and further away, you don't think so much of having a cigarette. If you know what I mean. So if you are on your seventh day, you are not thinking about having a cigarette, as much as you did on your second and third day. And so forth, and the time when you think about having a cigarette, stretches out longer, and longer, and longer. But I did find that sometimes, it came in quite hard that you wanted, although you stretched it, out for ages and ages, when you thought about it, you thought I could murder a fag like.*

(Harry, 69 years, working class)

Harry was making a fundamental change to the structuring of his daily life, for smoking was an integral aspect of his social world, and it was evident in his description that the temporal structuring of his daily life had changed significantly: moments between time were documented and noticeable within his account as they signified the time since Harry last smoked a cigarette. Alongside the addictive nature of smoking changing habitual practices requires a conscious and determined effort as the logic of daily living has been questioned and challenged.



## (2) Gender, class and care

There were many factors that influenced the structuring of everyday life that included household structure, gender, class and identity. The rhythm and structure of domestic life was predominately described, by the participants, around the care of the body, for example, the routines associated with eating, sleeping, bathing and dressing (cf. Twigg, 2006). Choices about lifestyles were therefore mediated via the home and domestic life, and whether the participants lived alone, in a couple and/or with other family members. Gender was significant with women predominately taking responsibility for food and cooking:

*My wife, in particular, being a cook, is very interested in food, and very conscious of what is good for you, and what is not good for you. So we eat brown bread, we have got a very good juicer, for orange juice in the morning, and citrus fruits, carrots and apples, so we use a lot, and we tend to have our main meal, in the middle of the day.*

(Derek, aged 67 years, middle class)

Within the everyday discourses the men frequently relied on women in terms of their dietary practices, and the women described their key role in choosing food, shopping and cooking. Participants who changed household structures, such as moving from a two person to one person household, said that their dietary practices had not changed significantly although they would eat out more frequently and / or use more convenience foods when living alone.

Key constraints on changes to lifestyles were financial resources, bodily limitations and caring responsibilities that at times interrelated to limit participant's choices. Five

of the participants were tenants in Housing Association properties and received income support (see appendix one). These participants described lack of financial resources that limited their ability to buy ‘healthy’ food and access additional ‘health’ consumer items, such as alternative therapies and exercise classes. Moreover, their social activities were significantly rationed. This was especially evident for participants who were also carers whose access to wider social networks was significantly constrained (see also chapter 4). For others, the combination of ill health; disabilities, such as, blindness and persistent pain; and lack of financial support interconnected to severely limit their opportunities and choices. Harry, for example, experienced continual back pain and had retired early as a lorry driver following a work related injury. Since this time he had lived on income support:

*Well I can't do much else, I have to watch what I eat, with diabetes. I can't do any running, or anything like that. So basically no. There is not much else I can do, you know.*

(Harry, aged 67 years, working class)

Living on limited financial resources rendered making future plans and decisions difficult. The immediacy of everyday life was central with limited resources to rely on: financial concerns permeated the biographical discourses. For example, Gill's response to the first question of the interview ‘What has been important in your life?’:

*Gill: Children. My health. My husband. Existing from one day to the next, I suppose.*

*Int: What do you mean existing one day to the next?*

*Gill: Paying the bills.*

(Gill, aged 70 years, working class)



Paying the bills was the main and continual worry around which all other aspects of daily living revolved. Living with limited resources resulted in the participants being careful about all expenses and very astute about their choices in everyday life, frequently described as ‘cutting the cloth’ within the limitations of their own resources. The importance of money was frequently discussed for all aspects of their everyday life required conscious deliberation. The financial viability of all their choices had to be considered:

*I suppose, if you was to sit down and think about it, money would be important. We have always cut our cloth, according to what we have had, like, you know. We have never gone out, and spent on things that we couldn't afford. We had to afford things, before we went out and bought them, if you like, so we are all right in that respect, like, you know. I think as long as you are fed and watered, it is not too bad. I think as long as you have got enough to live on, and you are not in debt, and you haven't got worries over that, I think that is fine like. I know some people want to, seem to want more, and more, and more, for stuff that they don't need. But as long as you have got enough, you can cut your cloth accordingly, like, you know I think that is fine. I always have thought that.*

(Harry, aged 67 years, working class)

Opportunities and possibilities were therefore severely constrained when living on low incomes: the immediacy of getting by on a day to day basis was central. It is especially pertinent to note that all the participants living on income support experienced a multiplicity of disadvantages that included disabilities, ill-health and caring responsibilities: all had retired early for one or more of these reasons.

### (3) Age, Ageing and the Lifecourse

Many of the participants described the extent to which the context of health and health promotion had changed during their lifetimes. Modern lifestyles were described as different. Not only were there more choices but perceptions of risks had changed over their lifecourse. A heightened awareness of risks, such as eating less sugar and fat, had seeped into the fabric of their everyday lives:

*Well, to look after what you eat, not so much fat, and not too much butter. Don't fry things, don't eat so many sweets, biscuits, crisps. Oh yes, you do think about it, yes. Because you realize, it is not all that good. Like I mean years ago you used to cook your meat in the oven, and slobber it over with fat or lard. But I mean now I don't, I just put a bit of water in the bottom of the tin, and cover it, and it cooks just as well. And in fact you get the goodness out of the meat. But there are lots of ways, and as you get older, certain things don't agree with you. I don't know why, but now I have got older, I can't eat baked potatoes much, because they give me indigestion. I like vegetables. I have always liked vegetables. Any vegetables. I eat plenty of them, and fish. I love fish. But fried food you know. Years ago they used to want fried bread, and put dripping on bread. I mean we used to get that, when I was a kid. Beef dripping. It was lovely. But I wouldn't dream of eating it now, because of my cholesterol.*

(Gill, aged 70 years, working class)

Across the lifecourse both perceptions of and experiences of health risk had changed: in particular, distinctions between 'healthy' and 'unhealthy'. Now there was greater



awareness of risks to health although not all aspects of modern lifestyles were viewed as healthier. Participants were critical of the greater reliance on convenience foods rather than home cooking and excessive exercise was questioned. The heightened sense of anxiety and uncertainty from changes over time were observed and criticised. At the same time many participants welcomed the increased knowledge about certain health risks, such as, smoking and cholesterol.

Age and ageing was often drawn upon as an explanation for changes in relation to lifestyle choices and perceptions of risk. Many participants had moderated their diet due to increasing bodily discomforts they experienced, such as, feeling ‘uncomfortable’ and increasing indigestion. Other participants had started exercise regimes and stopped smoking. Growing older was viewed as the rationale for these changes due to bodily experiences and notions of subjective well being. Some participants cited their age as ‘proof’ that their lifestyle choices were effective regardless of the advice of experts: living longer demonstrated ‘success’ in active ageing. Alternatively some participants questioned the need to change everyday practices now that they were older:

*Sometimes I think, oh I have overdone it today. But you see the trouble is, when you see the adverts on the television, it is awful, dreadful. And I can still light up a cigarette, whilst I am watching that. And that is bad. But yes, I am having a try. Although so many people say to me, well at your age why bother.*

(Sophie, aged 78 years, working class)

*Granny, your lungs, granny your. He goes on, and on, and on. And I say, I have got to my age, and I might as well go out being happy.*

(Catharine, aged 83 years, middle class)

Whilst old age was viewed as a reason for continuing with practices that had been designated as ‘unhealthy’, these choices continually needed to be negotiated in relation to the perceptions of others, such as family, and risk discourses of health that point to the negative effects of smoking. This required a balance, for example, between subjective choices in relation to the immediacy of enjoying a cigarette with the perceptions and concerns of others for their long term wellbeing.

#### (4) Health as ‘release’

Alongside the notion of health as an active process that needed to be worked at was an alternative discourse that emphasized dimensions of life that were pleasurable (cf. Crawford, 1984). Following advice about potential health risks required willpower, self control, self discipline and a process of continual monitoring of everyday practices (cf. Crawford, 1984). In contrast, many participants expressed the importance of enjoying life and the importance of treats and having fun:

*The minute I saw, that nice pile of bread I was happy, nice unhealthy butter, I was perfectly happy. People seem to want, or need to, eat things that are healthy, and I don't quite know what that means. I mean I have heard the word cholesterol, but I haven't got a clue what it is. But I am sure mine is fairly high, or low, whichever way it is. It doesn't worry me in the slightest. I have lots of sugar, and lots of salt. I love sugar, I love salt. It doesn't concern*



*me in the slightest because I am going to have it, I enjoy it.*

(Ken, aged 64 years)

The pursuit of enjoyment and pleasure within everyday practices denoted a sense of bodily invulnerability and / or hedonism: the immediacy of the experience is emphasised instead of the unknown but possible consequences in the future. At times the additional anxiety about different health scares was portrayed as ‘unhealthy’. A number of participants described the importance of balancing the immediate with the future, and emphasized the importance of moderation within their lifestyles:

*I mean, I know we don't eat the right foods, all the time. Life wouldn't be worth living with it, but if you eat, sort of reasonable, you know. I mean they tell you not to eat salt, and that which I do you know.*

(Tony, aged 78 years, working class)

The phrase ‘*a little of what you fancy does you good*’ was expressed by many participants: life was not only about discipline but to be enjoyed too. For some participants, when difficult emotional experiences, bodily limitations, low income and / or ill health impacted on their daily life having treats, eating what they enjoyed and / or smoking eased their personal difficulties:

*I suppose in times of stress, you know. I have had a lot of ups and downs, lots of things. I mean we found out my son was ill. He was got Meniere's disease, and then we found my other son has the same thing. And my oldest daughter was psoriasis and diabetes. And various other things, you know, and you seem to get one shock on top of the other. And I can't give up, I think to myself, I have got to have something.*

(Gill, aged 70 years, working class)

Some participants continued with their everyday practices as they enabled them to cope more effectively with their immediate lives. At times the pursuit of the immediate and the pleasurable were therefore emphasized.

#### (5) Personal responsibility, fate, luck and chance

Health promotion messages that advocate changes to health related lifestyles promote the idea of personal responsibility. Many participants however were critical of the advice of experts, in particular, the contradictions and inconsistencies within health promotion discourses. The way experts disagreed with one another was often criticized:

*I think they are ridiculous, because you get coffee is bad for you, coffee is good for you, wine is bad for you, wine is good for you, don't matter, what any one says is good for you, someone will come up, and say it is bad for you, and vice versa, but I agree with the salt, I must agree with the salt. I had something a little while back. I went down to the supermarket, and I got a package meal, this particular meal, and oh it was salty, ever so salty, so I complained.*

(Harry, aged 67 years, working class)

The participants did however need to make decisions between these different health promotion messages within the context of their everyday lives and described different ways in which they dealt with these inconsistencies and contradictions. Some participants used their own personal experiences and awareness of their bodies to know what was right for them. Others argued the importance of moderation and



reasonableness in relation to their everyday practices. A few of the men chose not to engage with the health messages at all:

*It would be ridiculous, if nobody was paying any attention, of coming up with them. I have an intense dislike, of how often they make a statement, and then they change it a year later, and virtually invert it. I personally, don't follow it, when they come out, with all the things that are good or bad for, I will continue to eat and enjoy what I eat and enjoy. I have got no problem with the issues and the statements, and what have you, but I choose whether it is right for me or not. I eat what I want to eat.*

(Ian, aged 69 years, middle class)

Some participants, mainly middle class men, therefore decided to continue practicing what they enjoyed regardless of the advice of experts: they rejected the notion of personal responsibility for their health in this context.

There were further explanations for health that questioned the concept of personal responsibility for health. Many participants described health in terms of chance: being healthy was due to luck and / or good fortune (cf. Davison *et al.* 1991, 1992). Some of the participants believed in the idea of fate. Fatalistic notions of health were therefore evident:

*I have to be careful here, because I am not a fatalist, I don't believe that absolutely everything is planned, and we have no control over our lives, I do believe that life has a pattern, and you know, there is a pattern for us. And my life certainly shows, that no matter I have to face, things work out for the best in the end. And you might be sad at the time, about what is taking place in*

*your life, but looking back upon it, you know there is a pattern there, and I believe that there is a pattern for the best.*

(Bill, aged 60 years, middle class)

The idea of fate questions, to a certain extent, that a person has control over the pattern of their lives: however, fatalistic notions did not necessarily preclude notions of personal responsibility. However, some of the participants did believe that there was an underlying pattern to their lives that they did not fully understand or know but was evident in their biographies:

*Margaret: No not really. And I have never bothered you see. There again, I never bother with myself. I couldn't be bothered having a scrape, or whatever it was. I am still here. There is a reason, there is a reason, why I am still here.*

*Int: What do you mean?*

*Margaret: Well I never bother with myself. I mean I never get check ups here, check ups there. I never bother. It doesn't interest me. And as I said I am still here.*

(Margaret, aged 87 years, working class)

Whilst a number of participants had the belief that there was a pattern to their lives, the two oldest participants, aged 87 years and 96 years, both believed that there was an unexplained purpose for their longevity: an underlying reason that they did not know or understand. Perceptions of fate, luck and chance were therefore also significant for the participants.



### **‘Old age’ as a discourse of risk**

Underpinning perceptions of risk and vulnerability about growing older were concerns and notions of the possible negative consequences of (deep) ‘old age’. Growing older was constructed as a discourse of ‘risk’ that increasingly focused attention on old bodies. Old bodies were moreover to be avoided and distanced:

*The reason I go is to be supple, I don’t particularly want to be able to turn head over heels, or do something stupid like that. Well in a way, but what I am guarding against the other side, aren’t I. Guarding against having to walk with sticks, and, I would hate at the moment being 71, and wearing glasses for people my age, and unfortunately for people who are in homes, where you sit on a chair, and you go like this, and you stretch like that, and you roll a ball round in your wrists, and I think I don’t want to do that, until I am about ninety. So you know you are saying what is important. That is important, that I haven’t got to that stage yet. But it will get me some other way, won’t it.*

(Marilyn, aged 71 years, middle class)

Underlying the imperative to be active within everyday life was the goal of delaying any perceived negative consequences of old age for as long as possible. Negative consequences cited included being dependent on others, walking with sticks, being housebound, immobility, and moving into a nursing home. The significance of activity in daily life was therefore to promote health, prevent ill health, and avoid ‘old age’:

*To try and keep active, because I think one thing, that can exacerbate it is, if you give up, and just sit and do nothing, become the couch potato. I think that probably can bring on the onset, I don’t want to do that. But I accept that*

*something probably will happen to me in the future, but until that happens, I will do as much as I can.*

(Simon, aged 58 years, middle class)

The vulnerabilities of the body and the inevitability of ageing underpinned these discourses. Some participants distinguished between vulnerabilities associated with the body and mind:

*I want to stay healthy, more than anything. Because I think, if you are healthy, you can do all sorts of things. So I swim, I line dance. I do aerobics, anything that I can think of, that is enjoyable, to keep me going, for as long as possible. And I dread anything that, I think for a long time, would it be worse for your body to go, or your mind to go, and I think, it would be probably be worse for your body to go, and your mind is still working, and you know that you can't do it. Whereas if your mind goes, you don't really know too much about it. I don't want any of it to go really.*

(Anna, aged 67 years, middle class)

Within these discourses some participants dreaded the vulnerabilities associated with the body. For others concerns were about vulnerabilities associated with the mind:

*It must be terrible to have, it must be terrible, for other people, well you don't know, I suppose, but to think to have Alzheimer's. A terrible thing isn't it.*

(Fay, aged 80 years, middle class)

The imageries and imaginings of old age were frequently depicted as a negative and unwelcome stage of life. The spectre of losing bodily control moreover loomed large:

Janet: *Well as I have got older I am, more and more of my relatives have got*



*old and infirm, friends, parents, and so on, have got older and infirm, one thinks, I think, it doesn't worry me really, but I am concerned that I don't become senile. It is very distressing to see people, family and friends, who really go downhill and become nothing more than cabbages, in a way, and don't really know what is going on, being looked after, it is all going back to babyhood, and I find it very very sad.*

Int: *Does it worry you because of the lack of control?*

Janet: *Not knowing.*

Int: *Not knowing about the future.*

Janet: *What you are doing, or not having a mind to think. You don't know, do you. You get these sort of dementia type things. I think it is not having control of your own self, and not being able to do what you want to do. It is a concern. It is a concern.*

(Janet, aged 61 years, middle class)

The uncertainty of the experience of old age, the fear of an unknown but anticipated future, was central to the participant's discourses about ageing and risk. Within this context old bodies were constructed as the distant 'other': the imperative of being active was to distance and avoid the negative effects of old age. Age and ageing were therefore increasingly constructed as a discourse of risk that focused on the vulnerabilities associated with ageing bodies.

### Concluding comments

This chapter explored the participants own ideas about health, health-related lifestyles and risk in everyday life. When situated within the context of everyday life the

participant's perceptions of health were interwoven with discourses about risk, vulnerability and the ageing body. Awareness of the body was significant when engaging with health discourses of risk. Underlying discourses of health and risk was an underlying sense of vulnerability associated with old age and bodies. In particular, ageing was constructed as a discourse of risk that increasingly focused on the ageing body. Old bodies were therefore constructed as 'other': to be avoided and distanced within the everyday worlds of the participants.

The meanings and interpretations about health promotion discourses were complex and involved intricate interconnections between expert discourses of 'risk' and the participant's own localised and everyday logic. Participants did not only choose between different expert discourses of health risks when negotiating lifestyles. The process of reflexivity was therefore complex and multifaceted as the participants own localised and everyday logics interweaved with expert discourses on health and risk. In particular, there were a number of factors that influenced the choices that participants made in relation to health related lifestyles, which included, gender, chronological age, living arrangements, health as 'release', and daily habitual practices. When situated in the context of the daily lives of participants, there were therefore facilitators and constraints to engaging with health practices that question the salience and limitations of the notion of 'risk' and 'reflexivity' in the daily lives of the participants. These considerations will be further explored next during the discussion chapter.



## **Discussion: Bodies, Emotions and Risk in Later Life.**

*Even as age came closer and closer to me personally, I kept asking myself if denial isn't better, healthier. Did I really want to open this sinister Pandora's box? For there was nothing truly to look forward to – nothing I wanted to claim as “us” – in the image of old age as decay and deterioration.*

(Friedan, 1993, p. 9)

On the basis of the data collected and analysed during this research three overarching and interconnected themes emerged. First, the body was a taken for granted aspect of everyday life until moments when bodily experiences and / or the ‘doing’ of the ageing body interrupted the participants’ daily activities. It was at these moments when the everyday visibility of the body was heightened that the participants reflected on their own meanings and identities associated with growing older. Second, emotions were interwoven into the participants’ discourses as they described their daily lives and social interactions. In particular, there was a continual tension between inner (private) subjective feelings and *experiences* of emotions and the outer (public) bodily and spatial *expression* of these emotions. Third, the process of risk profiling and reflexivity was complex and multifaceted as participants drew upon a number of different discourses when making choices about health related lifestyles. Underlying the participants’ discourses about health and risk was a sense of

embodied vulnerability in which ‘old’ bodies were constructed as ‘other’ to be avoided and distanced from their everyday worlds and identities.

At the beginning of this thesis I observed that a key problematic for older people was the tension resulting from two alternative images evident within the concept of active ageing: that is positive (*active*/ freedom/ fluid) and negative (*passive*/ dependence / decline) images of ageing. Having explored people’s lived experiences of everyday life in the context of alternative imageries of ageing, a more inclusive account of the lived experiences of growing older has been illuminated. In particular, I have gained more understanding about the complex and fluid interrelationships between imageries, discourses, ageing bodies, emotions, perceptions of risk, personal biographies, and socio-cultural processes, that shape and inform meanings and experiences of people as they grow older. This chapter will further examine these interrelationships in relation to the following themes: (1) revisiting masking theories; (2) the salience of and limitations to ‘risk’ and ‘reflexivity’; (3) active and passive images of ageing; (4) the centrality of the ageing body; and (5) researching lived experiences: the biographical and the visual.

### **Revisiting masking theories**

In chapter one, I suggested that our understanding of masking theories may be enhanced by empirical research situated within the everyday lives of older people. On the basis of the data collected for this research study, I will now revisit the following dimensions of masking theories: (1) interconnections between an (inner) youthful self, an (outer) ageing body and the socio-cultural milieu; (2) identification with and



resistance to the social identity ‘old’; and (3) the experiences and expressions of emotions.

Due to the shifting and changing nature of the interrelationships between the ageing body, inner self and the socio-cultural context, definitions and explanations remain elusive (cf. Lupton, 1998<sup>34</sup>). Instead this study has gained insights into the meanings and perspectives of older people, and the ways that these interrelationships were explained in the context of everyday life. The data from this study, especially the photo-elicitation method, has shown that interconnections between an (inner) youthful self, an (outer) ageing body, and the socio-cultural milieu, were complex, ephemeral and, at times, contradictory. In the context of the participant’s everyday lives this distinction was frequently articulated as boundaries between inside and outside the body: whilst *inside* the participants did not always feel different from previous chronological ages, they did recognise changes to the *outside* of the body in relation to bodily appearance, such as wrinkles and grey hair. The inside of the body was however neither synonymous with an ‘ageless’ self (Kaufman, 1986) nor an eternally younger inner self (Hepworth, 1991; Featherstone and Hepworth, 1990, 1995a, 1998). Instead the inner subjective self, like the ageing body, was transient and changing in nature: whilst the inner self at times felt subjectively young, at other times, the participants recognised and valued the sense of maturity gained from being an ageing self.

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<sup>34</sup> This is a similar argument that Lupton (1998) makes about the nature of emotions.

The meanings and explanations given by the participants were understood in relation to their own localised and everyday socio-cultural contexts. So, for example, participants described heightened awareness of (outer) bodily changes, that felt distinct and separate from their sense of (inner) self, during episodes within their daily lives, such as, from glimpses of the (whole) body in a mirror, in response to visual cues, and during social interactions of everyday life. Bodily changes were recognised both inside (such as, aches and pains, limited mobility, muscle changes) and outside of the body (such as, sagging skin, increased body weight, and greying hair) (cf. Ballard *et al.*, 2005). At other times participants articulated a sense of self that had matured and aged, a confidence and knowledge that could only be achieved through ‘years of experience’. The interplay between these changes and associated interrelationships between ageing bodies and subjective selves were moreover dependent on the changing socio-cultural context in which they were occurred. The meanings and ideas about age and ageing were, for example, expressed in relation to other social actors, visual cues, and were mediated via the lived experiences of the body. The inner self was therefore inextricably linked to the corporeality of the ageing body and explanations that participants gave about their embodied selves were located and experienced as part of being-in-the-world.

A central principle underlying masking theories are that older people will participate in age resistant activities in order to maintain a youthful appearance. The incentive to appear more youthful results either from an ageist society in which youth has a higher symbolic value than old age (Biggs, 1997), or from a post-modern desire to present an appearance that resonates with an inner sense of youthfulness (Featherstone and



Hepworth, 1990, 1995a, 1998). When situated in the context of the participant's everyday lives there were a multiplicity of different positions. Some of the participants, especially the women, discussed engaging with activities that changed visible bodily signifiers associated with ageing, such as, colouring hair, pedicures and wearing of make-up. For some of the participants the desire was to look younger, for others to present an acceptable embodied self in the social world. Gender was significant to perceptions of age-resistant activities, with the men predominately concerned with the functionality of the body, and the women with bodily appearance. Many participants also described the significance of age-appropriate dress and appearance, and in this context, aimed to present an image in the public world that not only reflected their subjective sense of ageing self but was deemed to be socially acceptable (Ballard *et al.* 2005). Social class differences can not however be underestimated: people on limited financial resources undoubtedly had significantly reduced opportunities to engage with the ideas and possibilities of age resistant activities.

Participants did however consistently distance themselves from the signs of (deep) old age, which included, acting old, limited mobility, dependency, being housebound, and being bodily frail: imaginings of 'old' were moreover frequently associated with old women. Avoidance of negative associations with old age was achieved by *being active*, that involved, taking exercise, maintaining an active mind, learning new skills, being busy and being socially active. As ill-health and old age are constructed as synonymous (Conway and Hockey, 1998) the motivators behind active lifestyles were a complex interconnection between the distancing of old age and the avoidance

of ill-health. At the same time, in certain contexts, for example, when observing the visual images, when describing bodily limitations, and when observing the (outer) bodies of peers, participants did also identify and associate themselves with the social identity 'old'. Participants did therefore engage in a complex process of identification with and resistance to the social identity 'old'. In particular, the oldest participants, in terms of chronological age, found the ability to distance from the identity of 'old' increasingly difficult, and their discourses involved a complex interplay of references to being 'old' and distancing themselves from negative aspects of deep 'old' age. Aspects of growing older were therefore not embraced, but there was a resigned acceptance and identification associated with growing older as a natural and inevitable part of everyday life, rather than evidence of strenuous attempts to resist the ageing process (cf. Ballard *et al.*, 2005)<sup>35</sup>. Whilst social identities were changing, contradictory, and in flux, when situated in the context of older people's social worlds, these identities were experienced as logical and natural aspects of everyday life, as they attempted to make sense of changes associated with growing older.

Despite the focus in masking theories that older people have significantly reduced opportunities to express their own subjectivity and feelings in the social context (Hepworth, 1998), experiences and expressions of emotions were interwoven throughout the discourses of the participants as they talked about their biographies

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<sup>35</sup> Ballard *et al.* (2005) differentiate between public ageing (visible / physical changes to outer body) that have potential for age-concealment activities; and private ageing (less visible, associated with physiological changes inside the body) that are seen as irreversible markers of ageing. Whilst in my study there was a distinction between inside and outside the body, age resistant activities, such as exercise and keeping active were also evident, and therefore if these activities are defined as age resistant (that as argued above is unclear if old age and ill-health are constructed as synonymous), there was no obvious differentiation between age resistance in terms of inside and outside the body.



and everyday lives. Lived emotions were an integral dimension of the participant's social worlds: the intensity of emotions, such as grief, pain, love, joy, fear and anger, providing levels of depth and authenticity within biographical and everyday lives (cf. Lupton, 1998). The data was moreover able to illustrate the nuances and the socio-cultural context of the experiences and expressions of embodied emotions in later life. There was, for example, a need to conceal emotions perceived as negative: in particular, to contain negative emotions not only within the body but within private space. The strategies to deal with painful emotions were further related to gender. For men, this predominately involved the pursuit of solitary pursuits, and for women, to engage with social networks and share their own feelings with significant others, mainly with other women. It was however the intensity, fluidity and persistence of emotions at critical moments, such as, bereavement, retirement, and divorce, that were experienced as so unsettling and destabilising for the participants (cf. Lupton, 1998). At these times participants were continually managing their emotions across bodily and spatial boundaries, in particular, between public and private space. This research has therefore elicited important perspectives about the experiences and expressions of emotions in later life that illuminate the subjectivities of older people that exist over and beneath the 'mask' of ageing. Emotions were indeed central to the lived experiences of the participants.

### **The salience of and limitations to 'risk' and 'reflexivity'**

Participant's perceptions of health, risk and ageing were informed and shaped by the broader societal discourses of risk associated with health promotion. There was therefore an awareness of the reflexive nature of expert knowledge systems in

relation to health related lifestyles. Underlying the analysis of Giddens (1991, 1998) is moreover the idea that people in contemporary societies are more responsive to risks as defined within health promotion (Lupton, 1999) evidenced by whether or not lifestyle changes are introduced (Giddens, 1991). In this context, risk profiling and reflexivity are seen to be conceptualised predominately as a response to expert knowledge systems (Lupton, 1999).

When situated in the everyday lives of the participants, the data showed evidence of both the salience of and limitations to the concepts of 'risk' and 'reflexivity'. Risks were represented as an ever-pervasive aspect of everyday life (cf. Lupton and Tulloch, 2002b) in relation to lifestyle factors, health risks and concerns for the integrity of the ageing body. Lifestyle changes were evident within the participant's lives, predominately in relation to diet, exercise, and smoking, that points to the salience of reflexive responses to risk. Participants did not however only choose between competing and different expert discourses of health risks when negotiating lifestyles, so that limitations to the concepts of 'risk' and 'reflexivity' were also discernible. The participants often had a critical and ambivalent relationship with systems of expertise, in particular, about the inconsistencies and contradictions within health promotion discourses. Localised knowledges were represented in which participants relied on their own experiences, habits, observations and ideas: in particular, personal experiences, bodily perceptions and subjective feelings, such as body weight, bodily symptoms, functionality and everyday comfort, were central to whether or not lifestyles changes were implemented. Alternative explanatory systems of chance, luck and fate were also articulated (cf. Davison *et al.*, 1991, 1992). The



privileging of the expert – lay relationship (Lupton, 1999) therefore underestimated the significance of localised knowledges, experiences of the body, and habitual practices that were central aspects of the participant's intimate and everyday perceptions and praxis of health risks.

In contrast to the universal rational actor portrayed in the work of Beck and Giddens (Lupton, 1999; Lupton and Tulloch, 2002b), reflexive responses to risk were also strongly shaped by gender, social class and chronological age. Lifestyle choices were influenced by gender. Women predominately had responsibility for food choices within the domestic environment. Men associated health and increased body weight to concerns about functionality; the women further highlighted their subjectivities, in particular, levels of (un)happiness associated with their bodily appearance. Expert discourses of risk also interweaved more frequently within the women's descriptions and ideas about their daily lives. Middle classed men were most likely to criticise and disregard risk discourses of health, preferring to make their own choices about daily life. Social class was also significant in relation to limited financial resources: lifestyle choices were severely curtailed and making future decisions problematic; the immediacy of getting by and making choices on a day-to-day basis were prominent in the discourses of the participants on low incomes. Definitions and perceptions of risks also had changed over the participant's lifecourse (cf. Lupton and Tulloch, 2002b; Zinn, 2005): in particular, whilst noting the benefits of having more knowledge about health risks, participants were critical of the increasing sense of anxiety and confusion resulting from the contradictions. In this context, new ideas about health risks were mediated via the participant's own knowledge gained over

years of experience; and being ‘old’ itself became ‘proof’ of success in the negotiation of health risks. Gender, social class and chronological age therefore interconnected to influence the participant’s ideas and practices associated with health risks: meanings were therefore related to subjectivities, social relations and structural factors; and primarily understood in the context of the participant’s immediate, everyday social worlds rather than solely on abstract concepts of risk as defined by expert knowledge systems.

The data did also clearly demonstrate the interplay of embodiment, ageing and reflexivity in everyday life (Riggs and Turner, 1997). In particular, the participants articulated a heightened sense of embodied vulnerabilities as they grew older. Embodied vulnerabilities, ‘ontological security’ as described by Giddens, are predominately managed through the development and maintenance of daily routines (Turner, 2004). However, the ability to manage daily norms and practices became increasingly problematic as the participants grew older as everyday routines were more frequently and, at times, unpredictably disrupted (Gubrium and Holstein, 2003a; Turner, 2004). Disruptions to daily routines and biographical identities included increasing awareness of bodily changes associated with ageing; experiences of ill-health, bereavement and divorce; and heightened concerns about everyday risks, such as, falls and mobility difficulties. The integrity and logic of the ageing body and everyday practices were questioned, the taken for granted nature of embodiment challenged, and older men and women compelled to make sense of biographical and bodily changes in order to maintain and / or re-negotiate a sense of ontological security.



Participants therefore continually fluctuated between ideas of ageing as a time of possibilities and opportunities, and an increased awareness of their embodied vulnerabilities, for many of their lifestyle choices were dependent on the integrity and well-being of their ageing bodies. These perceptions reflect the dominant alternative images of ‘positive’ and ‘negative’ ageing evident in expert discourses of active ageing (see chapter 1): whilst ageing can be conceptualised as a time of increasing possibilities and opportunities, at the same time, a sense of fear needs to be instilled to ensure older people engage with health promotion discourses. In this context, ageing itself was constructed as a discourse of risk that increasingly focused on the ageing body: old bodies were constructed as ‘other’ to be avoided and distanced within the everyday worlds of the participants. Embodiment was therefore central to reflexive projects of the self (Turner, 1995) as older people negotiated their identities with an acute awareness of the constraints as well as the possibilities of the lived body. The notion of embodied vulnerabilities, as articulated by the participants, therefore reflected a sense of the ontological reality of a body that was ageing physiologically; lived experiences given meanings in relation to the cultural and social milieu.

### **Active and passive images of ageing**

The ‘positive’ and ‘negative’ images of ageing also mapped onto imageries of active and passive embodiment that were interspersed throughout the participant’s discourses as they talked about their health, bodies, emotions and identities in everyday life. In particular, there was a distinction between presenting a ‘positive’

image of a performing and *active* embodied self in the public world whilst minimising and / or hiding perceived ‘negative’ aspects of growing older within the boundaries of private space. Ambivalence about the notion of home was evident, for whilst home was a space in which negative aspects of ageing could be hidden from the public gaze, at the same time, too long spent at home was itself a signifier of a passive old age. Ideas about active and passive embodiment were also influenced by gender, social class and the chronological age of the participants.

In this context the interconnections between the corporality of the ageing body and the socio-cultural context of lived experiences of later life was vividly illustrated in relation to boundaries between public and private space as articulated by the participants. There was for example ambivalence within the descriptions of the home space. Participant’s talked about concealing negative aspects of ageing within the boundaries of the home. So, for example, bodily limitations, pain and signifiers of dependence were hidden as much as possible from public view and limited to the private and intimate space. At the same time, being restricted to the home was associated with negative aspects of ‘old’ age, such as, being housebound, loneliness, and feeling low. Negative emotions were also predominately masked in public and limited to the privacy of the home. This was especially evident during times of change and loss, such as, bereavement and divorce: the home was both the space for the release of emotions and the prompt for the most painful emotions. Within the participant’s discourses there was therefore an ebb and flow between ideas of inside the home (private) and outside the home (public) that further mapped onto alternate



discourses of passive and active ageing. In particular, undisciplined old bodies were to be hidden from public view.

When situated within the everyday lives of the participants, complexities within and between alternative discourses of active and passive ageing were also articulated. In particular, ideas about active and passive ageing were reflected in the ways participants articulated a separation between the body and mind. Participants described the importance of maintaining an active mind and an active body, and different, but also interrelated, activities were associated with these embodied dimensions. Whilst activities associated with daily life were often described in relation to an active body, active mind, or both, there were differences in how these activities were defined that related to the participant's gender, chronological age, and social class. In particular, there were differences in whether activities were viewed as passive and / or active. Whilst some participants, described the significance of being active and doing exercise to their identities, as an active expression of their bounded and disciplined ageing bodies, for others, in particular, a number of the middle class men, the idea of doing exercise was rejected. Instead middle class men often described the importance of maintaining an active mind, rather than an active body, to their sense of masculine (and disembodied) identities (cf. Harper, 1997).

Discourses about passive and active ageing were further related to chronological age. Older participants, for example, described how watching television, such as current affairs and quizzes, promoted an active mind. For other participants, watching television, especially daytime television, signified laziness and passive imageries of

old age, that moreover, signified giving into and embracing the identity of 'old'. Other resistances to being active were also evident and the importance of rest was signified, in particular, and some of the women talked about the creation of space and time for themselves within the context of a multiplicity of roles and responsibilities. As Katz (2000) argues, the prominence of being active in later life has reinscribed the meanings of both leisure and what constitutes an activity. The data has shown that meanings associated with active and passive embodiment need to be understood in relation to the biographies of the participants, as perceptions of activity were mediated via gender, social class and chronological age.

Additionally active and passive discourses of ageing were not morally neutral, for whilst being active was actively encouraged, being passive was frequently discouraged and criticised (cf. Williams, 1990; Hepworth, 1995). Within the discourses of the participants, active and passive embodiment further denoted different personal characteristics (Hepworth, 1995; Higgs, 1998); so that, being busy and socially active was viewed as worthy, responsible and healthy; in contrast slowing down and / or having 'off' days were mainly portrayed as lazy and idle, and often initiated intense feelings of guilt. Virtues of self-control and self-discipline therefore lay behind notions of health (Crawford, 1984) and active ageing (Higgs, 1998) as described by the participants. In particular, participants described the importance of taking care of their embodied selves, implying increased attention to notions of self care and personal responsibility for current and future health. Being active was therefore not only an objective, a moral enterprise to resist the inevitable onset of old age (Williams, 1990), but activity itself was an evaluative criteria of later



life (Tulle-Winton, 1999), in which an active body was increasingly symbolic of virtues of self-discipline, health and identity.

Within the concept of active ageing the primacy given to active lifestyles and personal responsibility for health can therefore lead to the cultural repression of the declining and ageing body as negative associations of old age become increasingly hidden (cf. Tulle Winton, 1999). As Petersen and Lupton (1996) argue, new public health discourses are directed to ‘make up’ certain kinds of individuals. The tendency in the concept of active ageing to differentiate between success and failure in ageing (Gilleard and Higgs, 1998) leads however to the ‘doing down’ of other individuals who are unable to conform to the images of active and healthy old age. Vulnerable adults who experience deep old age, dependency and ill-health are therefore effectively marginalised and stereotyped. The nuances and meanings associated with active and passive ageing within the discourses of the participants reflected these complexities and tensions. The influence of social and structural inequalities, such as gender and social class, on the opportunities and possibilities of older people to be active were also underestimated. Older people were therefore compelled to negotiate their identities and lifestyles in the context of a central tension between an imperative to remain active within a corporeal body that was ‘slowing down’, ‘doing less’, and experienced as increasingly vulnerable. For as Gilleard and Higgs argue, the ageing body is moreover ultimately ‘the principle witness to our own success or failure’ (1998, paragraph 6.5).

### **The centrality of the ageing body**

The significance of the meanings and experiences of the ageing body were therefore central to the discourses of the participants as they talked about their daily lives, emotions and ideas about health and risk. In particular, the interplay between bodily processes associated with age and ageing and the social and cultural context in which they exist were shown to be important. In this context, the corporality of the ageing body was significant to the diverse and complex identities of the participants.

It is well recognised that the body is a taken for granted aspect of everyday life until bodily states, such as pain and ill health, intrude on daily routines and people become consciously aware of their corporeality (Bendelow and Williams, 1995; Williams and Bendelow, 1998). Perspectives of the lived body have not however previously been explored amongst older people. Data from this study has shown that as people grew older the everyday visibility of the body was heightened that led to participants reflecting on their own meanings and identities associated with age and ageing. In particular, the ageing body in everyday life was experienced as taken for granted until moments and / or times when an awareness of the body interrupted the participant's daily activities. This first included experiential changes to the lived body, such as, ill-health, aches and pains, bodily limitations, diminished energy levels and / or signifiers of ageing, such as wrinkles, increased body weight and / or greying hair. Alternatively bodily transformations were reflected back to the participants via visual and discursive images, from corresponding physical changes amongst family and friends and / or from glimpses of their own bodies in mirrors. Second, the 'doing' of age, ageing and the body was central to the participant's embodied participation in



everyday life. The participants discussed the ‘doing’ of ageing in terms of loss and / or achievement, body / mind maintenance and increased bodily limitations that impacted on their daily activities. Underlying the praxis of the ageing body in everyday life were moral discourses associated with active and passive embodiment, a sense of stigmatisation associated with bodily limitations, weighty bodies and / or ‘doing’ less. In this context the ageing body was not experienced as a constant presence in everyday life nor an absent entity but as in/visible transient and fluctuating absence / presence within the everyday lives of the participants (cf. Gubrium and Holstein, 2003a). It was the increasing visibility of the ageing body, concurrently omnipresent and transient, that needed to be managed and given meanings as people grew older. The control of bodily boundaries therefore became increasingly significant within the participant’s everyday worlds and their corporeality was central to their experiences and identities of ageing.

The interplay of gender and social class was also significant to meanings and perspectives of the ageing body. Men talked predominately about their bodies in relation to functionality and women in relation to their subjectivities and appearance. In this context masculinities, with an emphasis on ‘doing’ and performance, and femininities, with an emphasis on feelings and appearance, did intertwine with the participant’s perspectives on their ageing bodies (Calasanti and Slevin 2001). However, these categories were not distinct and separate in terms of gender and were also used interchangeably. In particular, growing older in gendered bodies was further differentiated by social class and chronological age. Harper (1997) for example has suggested that men become more embodied as they grow older, as it becomes

increasingly difficult to deny their corporeality. The data from this study has shown that this may resonate more with middle class men than working class men, and be further related to chronological age. Middle class men were more likely, for example, to disregard expert discourses on health risks, focus on performance in terms of their self and mind, and signify the importance of (disembodied) control within their lives in relation to their work (projects), emotions, and social relationships. In contrast, working class men, on low incomes, either had retired early due to bodily limitations and / or ill-health and therefore their bodily experiences had intruded into their lives and biographies at an earlier chronological age. Alternatively the strength and performance of a muscular body had been central to the occupation of the working class men and these bodily perspectives continued as they aged. Chronological age and / or dependency were also significant, for as the participants grew older, distancing from their bodies became more difficult: ideas of dependency and loss of performance was therefore an increasing challenge to their masculine identities.

Older women with more financial resources also had more opportunities and possibilities about how to express their embodied selves, in terms of exercise classes, holidays and aesthetic treatments but these experiences and expressions of the ageing body were also spatially as well as socially contingent. In this context the data from this study has illuminated the interplay between gender, the ageing body and the use of space. The women talked about the ‘doing’ of the ageing body predominately in the context of domestic space, such as, the family, the home and ‘doing’ housework. The men most frequently talked about ‘doing’ the ageing body in the context of gardening, walking outside, sport, and paid work. The research process also reflected



the gendered dimension of the use of space with more interviews conducted with women in their own homes than with the men. Masculine (public) and feminine (private) notions of space were therefore replicated throughout the lifecourse <sup>36</sup>. Chronological age was also significant. First, the majority of the oldest participants were accessed via the (chair) yoga within their sheltered housing scheme and via the café. Being old was predominately conducted in specific social contexts. Second, the chance to attend 50 + classes for computing, keep fit and yoga created a shared public space for the participants in which their ageing bodies and minds (as articulated by the participants) were given freedom of expression: the descriptions of a performing and an expressive ageing body, especially by the women, were most evident within this context (cf. Furman, 1997). As gendered and embodied agents in social space older people therefore both constructed and were constructed by their social worlds (cf. Nettleton and Watson, 1998). An exploration of lived experiences has therefore opened up the possibilities of understanding more about the spatial interconnections between the corporeality of the ageing body, emotions and the socio-cultural context in which older people perform their embodied selves.

As the participants grew older their own corporeality did however become more difficult to evade and limitations to the elasticity of ageing bodies were highlighted. This was increasingly evident when participants were 75 years and over, and / or experienced levels of dependency, ill-health and bodily limitations. In particular,

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<sup>36</sup> Whilst it is well documented that masculine identities are more closely associated with the public world of work, and women's identities with the private sphere of domestic life (Mowl *et al.* 2000), there appear to be few considerations (Gubrium and Holstein, 1999; Fairhurst, 2000; Mowl *et al.* 2000) of spatial dimensions in older people's everyday worlds.

there was a difference in the participant's discourses who were aged 75 years and over, who more frequently referred to being 'old', and their levels and expectations of *being active* significantly decreased. At the same time the participants continued to distance their identities from negative perceptions of old bodies, that were viewed as an unwelcome but inevitable aspect of life. In this context the focus on the promotion of active lifestyles became increasingly problematic for participants as they grew older. Whilst previous research has predominately focussed on people in mid to early old age, important insights can therefore be discerned from the perspectives of people in or approaching deep old age. In particular, the data from this study has shown how visible signifiers of ageing, such as, sagging skin, greying hair and bodily limitations, bring the physicality and physiology of the ageing body to the fore, and in particular, highlight the interconnections between an aging body and the socio-cultural context.

### **Researching lived experiences: the biographical and the visual**

The data collected in this thesis resulted from the intersection of in-depth biographical interviews and the method of photo-elicitation in order to elicit views and perspectives of people in mid to later life about their social identities, bodies, emotions, risk and imageries of ageing in the socio-cultural context. This final section will briefly evaluate the effectiveness of the data collection methods as way to elicit insights into older people's lived experiences.

A biographical approach has highlighted how life stories can elicit important insights into unique and unexplored areas of ageing bodies, emotions and risks within older people's everyday lives (cf. Wainwright and Turner, 2003). The interplay of gender,



social class and chronological age within the discourses of the participants has been clearly illuminated within the biographies and descriptions of everyday life as articulated by the participants. In this context, self-identities were not mere distinctive traits of the participants but reflexively understood in relation to his or her biography (cf. Wainwright and Turner, 2003). The emotional experiences, meanings associated with ageing and ageing bodies, and perspectives on risks, were given meaning to me as a researcher in relation to the life stories described: our embodied selves are therefore indeed embedded within our biographies (Gubrium and Holstein, 2000). An exploration of the everyday lives of the participants, the mundanity and ordinariness of daily living, has also allowed an exploration of the patterns, meanings and nuances of older people's lives (cf. Gubrium and Holstein, 2000; Twigg, 2003). In this context growing older was shown to be a central aspect of daily life that disrupted the taken for granted nature of embodiment and brought the significance of the body and emotions to the fore.

The use of the visual images further enabled an exploration of the participant's views on alternative images of ageing. The use of the method of photo-elicitation introduced different and at times contradictory meanings and perspectives. In particular, whilst the way older people distance themselves from the identity of 'old' has been well documented, the use of visual images in this study has effectively illustrated how participant's instead both identify with and resist images of being 'old'(er). The significance of the participant's own personal and social biographies was also significant into how the visual images were interpreted. For example, the responses to an image of couples were contingent on the participant's own

biographical experiences of coupledness. This therefore signified the importance of interconnecting different data collection methods, such as the biographical and the visual, when eliciting insights into the relationship between collective imageries and older people's own experiences and identities.

For me as a researcher the willingness of the participants to share significant aspects of their personal and intimate lives was a great privilege and, at times, felt remarkable. From my engagement with the literature I had anticipated that people in mid to later life would be reluctant to talk about issues associated with health, ageing, bodies and emotions within the interview context. As the data in this thesis has shown, on the whole, this was not my own experience. The participants were not only willing but appeared to enjoy talking about their biographical lives, their everyday experiences, and issues and concerns that were meaningful for them. In this context, public and private accounts of ageing, emotions and health were multi-layered and interwoven (cf. Radley and Billig, 1996) and looking at the visual images further elicited new perspectives and meanings about their identities, biographies and everyday lives. The use of visual images therefore acted as a prompt, or maybe a means of distancing from the personal or self-conscious (cf. Furman, 1997; Bendelow, 2000), and, at times, led to more intimate and private stories and meanings being voiced and shared. The trust and rapport achieved in the interviews, and the willingness of the participants to share their emotional and embodied lives, has therefore elicited important insights and understandings into their lived experiences. Like all people's lives, the social worlds of the participants were full of complexity and paradox, joy and pain, justice and injustice. Through the process of hearing and



reporting the voices of men and women in mid to later life, I have engaged with their own meanings, perspectives and concerns that can be seen to further destabilize and question the construction of ‘old’ as ‘other’.

### Concluding comments

The lived body approach to this study has elicited important insights about bodies, emotions and risk in later life. In particular, corporeality has been shown to be central to the identities, meanings and experiences of people as they grow older. Underlying the discourses of the participants was a moral distinction between presenting a ‘positive’ image of a performing and *active* embodied self in the public world whilst minimising and / or hiding perceived ‘negative’ aspects of growing older. In this context, the participants drew upon discourses in which old bodies were constructed as ‘other’ and thereby to be distanced and avoided. Participants further fluctuated between a sense of ageing as a time of possibilities, and an awareness of their own embodied vulnerabilities, for these opportunities were solely dependent on the integrity and well-being of their ageing bodies. Gender, social class and chronological age also interconnected to influence the participant’s ideas, everyday lives and practices, so that meanings and perspectives were directly related to subjectivities, social relations and structural factors. This thesis has therefore highlighted the significance of understanding lived experiences of ageing in relation to the social and cultural milieu.

## Conclusion

*Should we slow down because we are getting older, or hurry up  
because we'll not get any younger?*

(Anonymous, cited in Katz, 1988)

This research study identified a key tension underlying the concept of active ageing: the promotion of ageing as a time of possibilities and opportunities in the context of the inevitable onset of decline, deterioration, and decay associated with ageing bodies. With recognition of the increasing significance of the promotion of active ageing in the policy arena, this research set out to explore: (1) how older people negotiated their social identities in the context of alternative images and discourses around positive (active / freedom / fluid) and negative (passive / dependence / decline) ageing; (2) older people's own meanings and perspectives about their lifestyles, self-identities and bodies; and (3) the salience and limitations to the concept of 'risk' and 'reflexivity' in the context of older people's everyday lives. This final chapter will draw some key conclusions and sociological implications from this research and consider the significance of these findings for future policy and research.

Ageing bodies in everyday life have until recently received little academic attention (cf. Twigg, 2003). The data from this study has however shown that corporeality was central to the participant's lived experiences. In particular, the study has highlighted how the experiences and 'doing' of bodies were frequently taken for granted until some form of disruption heightened the conscious awareness of the body within the



everyday lives of the participants. One key source of disruption was growing older with the participants describing more frequent disruptions to their daily routines and biographical identities, such as, in relation to bodily changes; experiences of ill-health, pain, bereavement and divorce; and heightened concerns about everyday risks, such as, falls and mobility difficulties. The ageing body was not however experienced as a constant presence in everyday life nor an absent entity but as an in/visible transient and fluctuating absence / presence within the everyday lives of the participants (cf. Gubrium and Holstein, 2003a). In this context, Cartesian dualisms, separations between body and self, were predominately articulated and resurrected in the face of increasing disruptions to the body and self (cf. Leder, 1990; cf. Lupton, 1998) with 'old' being conceptualised as a distant 'other'. It was therefore the increasing visibility of the ageing body, concurrently omnipresent and transient, that needed to be managed and given meanings as people grew older.

This study also attempted to come to a greater understanding about how people in mid to later life defined, explained and interpreted their emotional experiences as embodied reflexive selves, in the context of particular socio-cultural milieus, that shape and reshape ideas of emotions (cf. Lupton, 1998). Lived emotions were an integral dimension of the participant's social worlds: the intensity of emotions providing levels of depth and authenticity within biographical and everyday lives (cf. Lupton, 1998). In particular, there was a continual tension between inner (private) subjective feelings and *experiences* of emotions and the outer (public) bodily and spatial *expression* of these emotions. The experiences and expressions of emotions were therefore contingent on spatial and social processes within the socio-cultural

context. The increasing significance of emotions evident in this research may further signify a process of reflexivity and emotional work that people in later life experience within an ever changing and uncertain social world. At the same time the emergent theme of emotions does bring into question the apparent lack of consideration of emotions in the daily lives of people in mid to later life in the context of research and policy. This oversight may further impact on the quality of life of older people. For example, when men and women draw upon different social networks and strategies at moments of emotional crisis, their own opportunities to access appropriate support to ensure the successful negotiation of painful emotions may be severely enhanced and / or curtailed <sup>37</sup>.

When situated in the everyday lives of the participants, the data also showed evidence of both the salience of and limitations to the concepts of 'risk' and 'reflexivity'. Lifestyle changes were evident within the participant's everyday lives, predominately in relation to diet, exercise, and smoking, that points to the salience of reflexive responses to risk. Participants did not however only choose between competing and different expert discourses of health risks when negotiating lifestyles. The participants not only had a critical and ambivalent relationship with systems of expertise, in particular, the inconsistencies and contradictions within health promotion discourses, but localised knowledges, experiences of the body, and habitual practices were also central to the participant's intimate and everyday perceptions and praxis of health risks. Underlying the participant's discourses about

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<sup>37</sup> For example, increased alcohol levels consumed at critical moments by the men in this study was notable.



health and risk was moreover a sense of embodied vulnerability in which ‘old’ bodies were constructed as ‘other’ to be avoided and distanced from their everyday worlds and identities. In this context old age and ill-health were frequently conceptualised as synonymous (cf. Conway and Hockey, 1998).

The discourses of the participants did therefore reflect key tensions within the concept of active ageing: the promotion of ageing as a time of possibilities and opportunities in relation to the inevitable onset of decline, deterioration and decay of an ageing body. Participants, for example, often described a sense of being active in an ageing body that was slowing down, doing ‘less’ and being experienced as increasingly vulnerable. ‘Positive’ and ‘negative’ images of ageing also mapped onto imageries of active and passive embodiment in which there was a distinction between presenting a ‘positive’ image of a performing and active embodied self in the public world whilst minimising and / or hiding perceived ‘negative’ aspects of growing older within the boundaries of private space. Being active was moreover both an objective, that is a way to ward off negative aspects of old age (Williams, 1990), and a criteria used to appraise later life (Tulle-Winton, 1999), in which active bodies increasingly denoted virtuous symbols of self-discipline, health and identity.

Significant implications for policies of active ageing have therefore been highlighted. First, moral distinctions made between active and passive embodiment can effectively marginalise and stereotype people who experience deep old age, dependency and / or ill-health. Second, the significance of structural and social factors, such as social class and gender, to people’s experiences and perceptions of (ill) health and well being

were frequently underestimated. Policies moreover need to develop an increasing sensitivity to the risk that the promotion of active ageing may inadvertently lead to the cultural repression of old and declining bodies in people's everyday lives. Old undisciplined bodies may therefore become increasingly hidden from public view. In this context the quality of life of people who experience deep old age, ill-health and dependencies may be significantly diminished.

This research project has therefore started to open up the possibilities of understanding more about the lived experiences of people as they grow older. By focussing on imageries of ageing and lived experiences of everyday life, my research study has been able to capture meanings associated with the fluid, complex and diverse experiences of growing older in people's daily and ordinary lives. In particular, the research has highlighted interconnections between gender, social class, chronological age and the ageing body that have not previously been considered. Limitations to this study are also evident. Future research, for example, could be enhanced by including a more diverse and heterogeneous group of people in mid to later life. Moreover, more in-depth research and integration between visual imageries in the socio-cultural context and people's lived experiences would be useful. This research has however highlighted the significance of corporeality to the lived experiences of people as they grow older, in particular, a sense of the constraints as well as the possibilities of the lived body. Meanings and experiences associated with growing older were therefore not only the consequence of biological processes of ageing but were also contingent on the social and cultural milieu.



## Accepted

by Elizabeth Jennings

*You are no longer young,  
Nor are you very old.  
There are homes where those belong.  
You know you do not fit  
Where you observe the cold  
Stares of those who sit*

*In bath-chairs or the park  
(A stick, then, at their side)  
Or find yourself in the dark  
And see lovers who,  
In love and in their stride,  
Didn't even notice you*

*This is a time to begin  
Your life. It could be new.  
The sheer not fitting in  
With the old who envy you  
And the young who want to win,  
Not knowing false from true,*

*Means you have liberty  
Denied to their extremes.  
At last now you can be  
What the old cannot recall  
And the young long for in dreams,  
Yet still include them all*

(141, *Growing Points*, 1975)

# **Appendix One**

## **Characteristics of Study Sites and Sample**



**Total number of participants = 50**

**Total number of interviews = 46 (42 participants interviewed alone; 8 as couples)**

*Gender:*

32 women  
18 men

*Table A: Study sites*

<i>Study site</i>	<i>Men</i>	<i>Women</i>
Yoga (7)	0	7
Yoga chair (5)	0	5
Keep Fit / sports centre (11)	5 (1 snowball = neutral)	6
Café (14)	4	10 (1 snowball)
Computing (13)	9 (1 snowball = neutral)	4 (1 snowball = neutral)
<b>Total 50</b>	<b>18</b>	<b>32</b>

*Table B: Sampling criteria by study sites*

	Men	Women
Active Body (22)	4	18
Active Mind (11)	8	3
Neutral (17)	6	11
<b>Total (50)</b>	<b>18</b>	<b>32</b>

*Characteristics of study sites:*

**Promoting an ‘Active’ Body:**

Yoga class for people aged 50 years and over (organised by Age Concern)  
Yoga class in sheltered accommodation (exercise took place in chairs)  
Keep Fit class at local sports centre of study area for people aged 50 years and over

**Promoting an ‘Active’ Mind:**

2 computer classes for people aged 50 years and over (organised by Age Concern)

**Neutral:**

Age Concern café in local town of study area.

Table C: Chronological age and gender

Age	Male	Female	Total
50-59	5	6	11
60- 74	10	18	28
75 +	3	8	11
Total	18	32	50

Table D: Social class and gender

	Male	Female	Total
Working	5	15	20
Middle	13	17	30
Total	18	32	50

Criteria to define social class included: main occupation (within biography or key occupation of main partner if never in paid employment), home ownership, entitlements to benefits and educational qualifications.

*Ethnicity:*

1 black Jamaican (woman)  
49 White.

*Marital status:*

26 Married: (15 women (1 with new partner); 11 men)  
6 divorced (2 women (1 with partner), 4 men (3 with partner))  
14 widow/ers (12 women; 2 men (both with partners))  
4 Single (never married) (2 women, 2 men (1 with partner)).

*Accommodation:*

7 participants lived in sheltered housing (1 of these was also housing association)  
5 lived in housing association/council properties  
38 were home owners (1 owned their council flat)  
1 lived in rented accommodation

*Employment status:*

35 retired  
5 participants received income support (2 men, 3 women)  
8 were in paid employment  
2 full time carers (women, for their husbands)



# **Appendix Two**

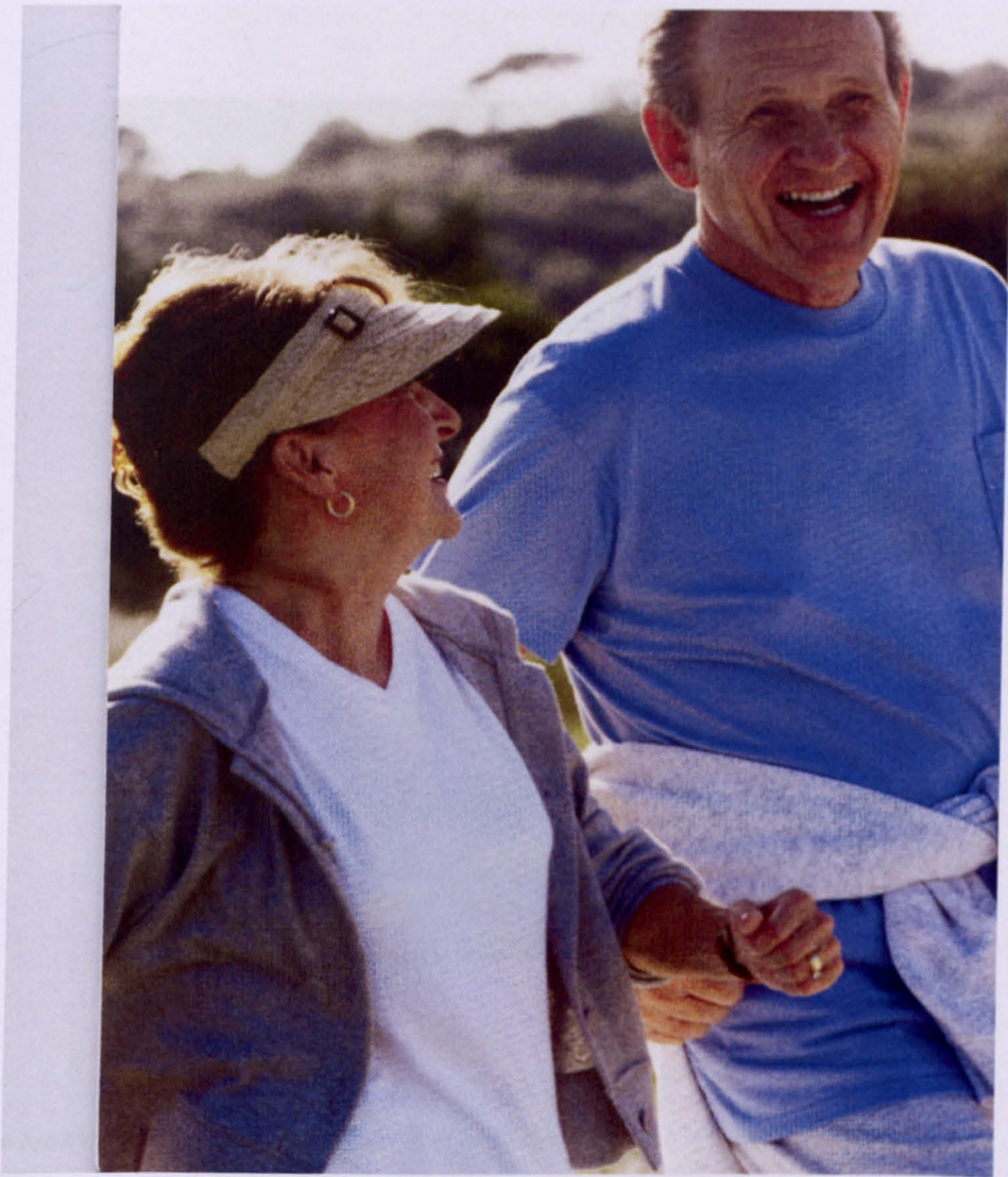
**12 Visual Images for  
Photo-Elicitation Method.**

**‘Vignettes’ presented in order used in interview.**



Visual Image Two:

**Visual Image One:**



Source:

*'Are you over 50?' A practical guide to advice, support and services across government* (2002) Department for Work and Pensions on behalf of the Cabinet Committee for Older People.

[www.over50.gov.uk](http://www.over50.gov.uk)

Visual Image on inner cover of booklet (contained 72 pages).



## Visual Image Two:



### Source:

*'Do you look after someone? Find out what help is available'*. Carers UK. Paul Matz publishers

[www.carersweek.org](http://www.carersweek.org)

Visual image on front cover of information leaflet.



### Visual Image Three:



### Source:

*'Falls. How to avoid them and how to cope. A practical guide for older people and their carers'* Royal Society for the Prevention of Accidents and Age Concern

Visual image on front cover of 8 page guide.



## Visual Image Four:



Source:

*'Promoting Better Health in Later Life. How you can take part in Ageing Well'*  
Ageing Well. Age Concern England.  
[www.activage.org.uk](http://www.activage.org.uk)

Visual image on front cover of leaflet.



### Visual Image Five:



Source:

'Memory problems?'. Memoryclinic.com  
[www.memoryclinic.com](http://www.memoryclinic.com)

Visual image on front cover.



## Visual Image Six:



### Source:

*'Do you have trouble getting around?'* Gerald Simonds HealthCare Ltd Bookmark.  
Gerald Simonds. Aylesbury

Visual image on front cover of leaflet / advertisement designed as a bookmark.

*'Are you over 50? A practical guide to advice, support and services across government'* (2002) Department for Work and Pensions on behalf of the Cabinet Committee for Older People.  
[www.dwp.gov.uk](http://www.dwp.gov.uk)

Visual image on page 28 of booklet is reprinted from the National Council for Voluntary Organisations and the National Coalition for Black Volunteering.



## Visual Image Seven



### Source:

*'Are you over 50?' A practical guide to advice, support and services across government* (2002) Department for Work and Pensions on behalf of the Cabinet Committee for Older People.

[www.over50.gov.uk](http://www.over50.gov.uk)

Visual image on page 38 of booklet in relation to REACH from the National Council for Voluntary Organisations and the National Coalition for Black Volunteering.



## Visual Image Eight:



Source:

*'Making the most of your retirement. How to enjoy your leisure time'* Age Concern England.

[www.activage.org.uk](http://www.activage.org.uk)

Visual image on front cover of information leaflet.



## Visual Image Nine:



### Source:

*Generations Review. Journal of the British Society of Gerontology* Volume 13,  
Number 1, January 2003

Visual image of 'hands' on front cover.



## Visual Image Ten:

Visual Image Eleven:



### Source:

*'Are you over 50?' A practical guide to advice, support and services across government* (2002) Department for Work and Pensions on behalf of the Cabinet Committee for Older People.

[www.over50.gov.uk](http://www.over50.gov.uk)

Visual Image on page 59 of booklet, section 'Keeping Fit and Healthy', 'Giving Up Smoking'.



Visual Image Twelve:

### Visual Image Eleven:



Source:

*'Understanding  
help you with...*

#### Source:

*'Are you over 50?' A practical guide to advice, support and services across government* (2002) Department for Work and Pensions on behalf of the Cabinet Committee for Older People.

[www.over50.gov.uk](http://www.over50.gov.uk)

Visual Image on page 29 of booklet, section 'Learning for employment or work', 'University of the Third Age'



## Visual Image Twelve:



### Source:

*'Understanding Alzheimer's Disease. Understanding Health. A series of booklets to help you with common health problems'* (2000) Hawker Publications. London.

*Information Leaflet and Request Form for Participants.*



# **Appendix Three**

**Information Leaflet and Request Form for Participants.**



If you have any questions, or would like some more information before agreeing to take part, I would be very pleased to meet with you.

### **Who am I?**

I am a research student at the University of Warwick. My background is in nursing and I am now working towards a research degree.

### **Please remember:**

- \* It is entirely your decision to take part
- \* You don't have to give a reason if you don't want to take part

**Thank you very much.**

# **Health, identity and everyday life**

*For further information please contact:*

*Wendy Martin  
Department of Sociology  
University of Warwick  
Coventry  
CV4 7AL*

*Tel: .....*

## **The Research Project.**

### **What's it all about?**

I want to talk with people over 50 years of age about their everyday life. The aim of the research is to talk with you about:

- what matters to you in your life
- how you plan and make choices in your everyday life
- your ideas and experiences of age and identity
- your health and lifestyle

I think it is very important to hear things from your point of view in order to understand the experiences that people have. It is important to know about your experiences of everyday life and your ideas about health and lifestyles. I would be grateful if you would consider taking part in my research.

### **What am I asking you to do?**

If you agree to take part I would spend some time talking with you on some aspects of this topic. I am especially interested in hearing about things from your point of view and about your own ideas and experiences.

The interview would take the form of a conversation and would be very informal. It could take place wherever you feel most comfortable. We would talk for about one hour and with your permission our conversation would be tape-recorded. Anything you told me would be treated as confidential and all names would be changed when the report is written at the end of the project.



# Health, identity and everyday life

## Request form

I would like to hear more about this project .....

I would be interested in taking part in this project .....

Name: .....

Contact address: .....

.....

.....

.....

Telephone: .....

**Or please call Wendy Martin on .....**

Please leave this form in the box provided

I very much look forward to hearing from you

# With thanks

# **Appendix Four**

## **Interview Schedule**



## Health, 'risk' and images of ageing in everyday life'

### **Interview schedule:**

#### Introduction.

I am interested in learning more about what is important to you. I am especially interested about what matters to you in your life, and in particular, about your daily life and the choices you like to make in everyday life. I will not be asking lots of questions, but will help you along as you talk, as I am interested in your views and experiences, although I do have a few specific questions towards the end of the interview. I also have a number of visual images I would like to ask you to look at.

Everything you tell me is, of course, confidential and I will change any names used in the written report. If I ask you anything you do not want to talk about or feel uncomfortable with, just say, and we can move on to something else. Is there anything else you want to know about the research, or about me, before we start?

First I have some very general questions to get us started.

#### Biographical:

What are the most important/significant events in your life? Can you tell me a little about your life, for example, where you have lived, your family, your occupation etc?

Can you tell me who are the most significant people in your life at present? (for example, social contacts, friends, family, carers etc.)

#### General overview

What sort of things do you enjoy?

What is important to you at present?

Is there anything in your life that worries you?

Would you to talk to anyone about something that worried you?

Is there anything you find difficult about life at present?

Is there anything you like to do, but can't.

Is there anything you don't like about life at the moment?

What do you find easy about life?

### Everyday choices/decision-making process/types of everyday decisions.

How do you decide how to spend your day?

Can you tell me about a typical day? For example, can you describe what you did yesterday?

How do you plan your week?

How do you make decisions about the future? (prompt if necessary, e.g. Health, holidays, family events, living arrangements)

Have you had any major changes in your life in recent years?

- Can you tell me about it?

- Who was involved in these decisions?

Is there anything you would like to change about your life?

Have you made any changes to your lifestyle?

### **Age and ageing**

What does age and ageing mean to you?

Is age something you think about at all?

What does it mean to be ..... (your age)?

Are there any changes in your life?

### **Health and lifestyle**

What does 'health' mean to you?

Do you feel healthy at the moment?

Do you have any concerns about your health?

What do you do for the sake of your health?



Have you changed any aspects of your lifestyle for the sake of your health? (e.g. Diet, smoking, exercise, stress)

If yes, can you tell me about it?

If you were feeling unwell, would you talk to anyone about it?

Have you had any illnesses? Who did you speak to about your treatment/condition?

Were you happy with your treatment? Was there anything you were less happy about?

### **Health promotion and risk factors**

Where do you gain information about your health / ill-health? Can you tell me about this please ...?

Do you ever discuss health promotion with a health professional?

Has any information ever influenced your lifestyle?

What do you think about the promotion of healthy lifestyles?

What do you think about the idea of active ageing?

Have you heard about any of these campaigns?

What do you think are the most important ways that people over 50 years can promote their health?

### **Vignettes**

**Images of ageing 12 photographs to discuss. To give the participant the 12 photographs and ask for the participant to sort out in terms of the significance of the image to themselves.**

What are your thoughts on the image?

How do you relate to the image?

What does the image mean to you?

Any comments on the content of the images/experience of talking about images

**Ask if the participant would like to find own images of age and ageing.**

Factual

Age (Date of birth)	Housing tenure
Previous occupation	Religion
Qualifications (education)	

Conclusion.

Did you feel comfortable with the interview? Was it what you expected? Is there anything I’ve missed out or anything you would like to add?

There are also issues about how the research is written up. Some ways of writing it up may mean that you might be recognised that it is you that is speaking, even though I will change your name or whatever. Is there anything that you have said that would worry you if you thought someone might recognise you?



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